Los Angeles County, Department of Public Health
Substance Abuse Prevention and Control

QUALITY IMPROVEMENT AND UTILIZATION MANAGEMENT MANUAL

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

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EXECUTIVE SUMMARY

Substance Abuse Prevention and Control (SAPC) is a division of the Department of Public Health, and is responsible for leading and facilitating the delivery of a full spectrum of prevention, treatment, and recovery support services for substance use disorders (SUD) across Los Angeles County.

Key organizational objectives are to develop a comprehensive, coordinated, and integrated continuum of care for the treatment of SUD that is accessible, evidence-based, effective, and sustainable. The Quality Improvement (QI) and Utilization Management (UM) Manual describes the goals, scope, structure and operations of SAPC's QI and UM programs, and pertains to all SAPC providers who deliver SUD services in Los Angeles County.

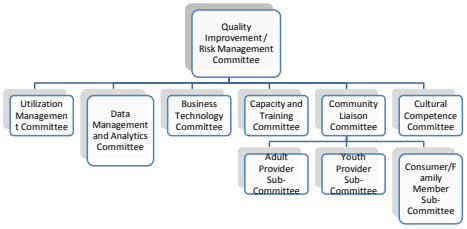
The broad objective of the QI and UM programs are for patients receiving SUD services to receive effective, coordinated care that is the right service provided at the right time, in the right setting, and at the right intensity and duration. Key objectives include:

- Supporting providers to help patients achieve recovery, stability, and functional improvement.
- Ensuring timely access to high quality, evidence-based, medically necessary SUD services in the most appropriate setting.
- Ensuring effective and efficient utilization of SUD services and resources.
- Facilitating and coordinating care between physical health, mental health, and SUD services.
- Ensuring the provision of services that are age-specific and developmentally, culturally, and linguistically appropriate.
- Involving patient support systems (e.g., family members, significant others), when clinically appropriate.
- Assessing, monitoring, and analyzing clinical performance and utilization, as well as outcome measures, to identify and promote opportunities to work with providers to improve service delivery, patient outcomes, and overall organizational and provider performance.

The QI program is connected with the UM program such that data, information, decisions, policies and procedures of one program aligned with the other. SAPC intends to coordinate such information and to create conditions such that the actions of one function are understood, incorporated and used by the other.

An internal SAPC committee structure will collectively review, address, and coordinate activities within SAPC, including those related to QI and UM, in order to provide an organizational infrastructure and culture to better meet its mission and objectives. These committees include:

- Quality Improvement / Risk Management Committee
- Utilization Management Committee
- Data Management and Analytics Committee
- Business Technology Committee
- Capacity and Training Committee
- Community Liaison Committee
    - Adult Provider Sub-Committee
    - Youth Provider Sub-Committee
    - Consumer/Family Member Committee
- Cultural Competence Committee



The remainder of this document includes brief overviews of both the QI and the UM programs. This executive summary does not include the same detail as the QI and UM Manual. If questions or concerns arise after reading this summary, please refer to the full QI and UM Manual for additional details. If the full manual does not address the question/concern, please contact SAPC at XXX-XXX-XXXX.

QUALITY IMPROVEMENT PROGRAM

Purpose: The Quality Improvement program ensures that the provision of SUD services aligns with SAPC's organizational mission and goals. Further the QI program will ensure that services follow a standard of clinical practice consistent with medical necessity, best practice, and level of care guidelines described by the American Society of Addiction Medicine (ASAM).

The QI program will implement two models in order to achieve these objectives:

1. *Continuous Quality Improvement (CQI)*: An approach to quality management that builds upon traditional quality assurance methods by emphasizing the organization and systems, and focusing on both internal and external "process" rather than individuals. The CQI model also promotes the need for objective data to analyze and improve processes.

2. *Chronic Care Model (CCM)*: The CCM identifies the essential elements of a health care system that encourage high-quality care. Elements include the community, health system, self-management support, delivery system design, decision support and clinical information systems.

Access to Care: One of the central goals of SAPC is to ensure that access to SUD services in Los Angeles County is timely (a Beneficiary Access Line will be established to facilitate more expedient and easier access to services), broad (Los Angeles County provides the majority of the levels of care noted in the ASAM criteria), evidence-based (providers will be expected to use a minimum of two evidence-based practices), and provided within the confines of Medi-Cal and other regulatory requirements.

Workforce: As a result of the Medicaid expansion in 2014, the SUD treatment population is expected to increase significantly. To address the workforce needs of this expanded population, Los Angeles County will work with provider agencies to provide trainings to enhance the quality and capabilities of the current workforce, while also exploring opportunities to expand their number. A diverse workforce in terms of discipline and cultural background will be crucial in order to address the varied needs of the SUD treatment population. Ensuring reasonable caseloads, continuing education, and career ladders as means for professional growth will also be critical in ensuring quality, individualized care, and workforce retention.

Documentation: Increasing focus on quality and a biopsychosocial model of care in the SUD field requires that health records (paper-based or electronic) be credible and complete, and meets specific documentation requirements of the payer (Medi-Cal). Los Angeles County requires that SUD treatment providers create initial documentation based on the ASAM criteria. In addition, progress notes must follow one of four formats: SOAP, GIRP, SIRP, or BIRP. The SOAP (Subjective, Objective, Assessment and Plan), GIRP (Goals, Intervention, Response and Plan), SIRP (Situation, Intervention, Response and Progress), and the BIRP (Behavior, Intervention, Response and Plan) are specific methods of documentation that describe the format and content of progress notes to ensure communication and monitoring of patient interactions. The full QI and UM Manual provides additional details concerning the

characteristics of each type of note (e.g., progress notes, treatment plans, assessment information, summary of progress, etc.)

Clinical Practice Guidelines and Evidence Based Practices (EBP): The QI program also includes descriptions of the medical necessity criteria, clinical practice guidelines, the appropriate utilization of medication-assisted treatments (MAT) and evidence based practices or EBPs (e.g., motivational interviewing, cognitive behavioral therapy, relapse prevention, trauma informed treatment, psychoeducation). SUD providers are at a minimum expected to implement the two EBPs of Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT).

Cultural Competency: Research indicates that culturally competent design and delivery of health services can improve outcomes in areas such as access, engagement, receptivity to treatment, help-seeking behaviors, treatment goals, and family response. Culturally competent care is an essential component to treatment and a state and federal requirement. SAPC will promote cultural competency by coordinating trainings designed to educate providers and administrators about various aspects of cultural sensitivity, with the goal of better engaging patients of diverse backgrounds and needs.

Special Populations: In addition to focusing on specific practices to treat SUD, the QI program also offer guidance on treatment for patients with more complex and specialized needs such as patients with co-occurring disorders, pregnant and postpartum patients, adolescents, young adults, older adults, patients involved in the criminal justice system, homeless populations, and LGBTQ (lesbian/gay/bisexual/transgender/questioning) patients. Although some EBPs have been shown to be effective when treating these populations, other clinical practices require further research (e.g., medication-assisted treatment for adolescents). Furthermore, these populations may have special needs (e.g., history of trauma, developmental needs, co-occurring mental health conditions) that may hinder the patient's progress if not addressed as a part of treatment.

Level of Care: Level of care determinations should be based on the ASAM criteria, which helps to organize the assessment and clinical formulation in a manner that increases the likelihood that a patient will receive the right service, at the right time, in the right setting, for the right duration. Referral to a specific level of care must be based on a comprehensive and individualized assessment of the patient, with the primary goal of placing the patient at the most appropriate level of care. In general, the preferable and most appropriate level of care is one that is the least intensive while still safely meeting the unique treatment needs of the patient.

Recovery Support Services: Recovery support services (RSS) refer to non-clinical services that foster health and resilience in individuals and families by helping them to navigate systems of care, and reduce barriers to employment, housing, education, and other life goals. They incorporate a broad range of support and social services that facilitate recovery, wellness, and linkage to and coordination among service providers. Similar to how patients see their primary care provider for periodic health checkups even when healthy, RSS can be viewed as aftercare or continuity of care in SUD treatment. The frequency of RSS is dependent on patient need, preference, and stage of recovery.

Case Management/Care Coordination: Research suggests two main reasons why case management is effective as an adjunct to SUD treatment: 1) retention in treatment is associated with better outcomes, and a principal goal of case management is to keep patients engaged in treatment and moving toward recovery; and 2) a patient may be more likely to succeed in treatment when other problems are

addressed concurrently with substance use. Case management and care coordination are critical aspects of treatment.

Performance and Outcomes: The QI program includes performance and outcome measures, quality improvement projects, and a peer review process for counselors and clinicians, with the goal of establishing an educational and evaluative mechanism for providers to contribute to the identification of opportunities to improve care and services. Confidentiality and risk management are also addressed.

Complaints/Grievances and Appeals: A complaint/grievance and/or appeals process is available for "involved parties" (patients, their authorized representative, or providers acting on behalf of the patient and with the patient's written consent) who are dissatisfied with elements of care including, but not limited to, services, treatment, or authorization denials regarding DMC eligibility, services, or level of care decisions. Involved parties may contact QI staff in these instances to discuss their concerns. Concerns that are not adequately addressed may need to be elevated to formal grievances or appeals. The procedure and timetables for submitting for these processes is outlined within the full QI and UM Manual.

UTILIZATION MANAGEMENT PROGRAM

Purpose: The Utilization Management (UM) program helps to ensure quality SUD services by monitoring adherence to the guidelines established within the QI program, including processes involving verification of DMC eligibility and medical necessity criteria, as well as appropriate clinical care and level of care and resource utilization.

In summary, the purpose of the UM program is to achieve the following objectives for patients and providers:

- Assure effective and efficient utilization of facilities and services through an ongoing monitoring program designed to identify patterns in under-utilization, over-utilization, and inappropriate utilization of services across the service continuum.
- Assure fair and consistent UM decision-making.
- Focus resources on timely resolutions of identified problems.
- Monitor adherence to the established QI and UM program guidelines.
- Educate health care professionals on appropriate and cost-effective use of health resources.

Importantly, the goal of the UM program is to ensure appropriate utilization of SUD resources and is NOT intended to screen out patients for necessary services or create unnecessary burden for providers, which is contrary to the organizational mission and goals of SAPC.

Initial screenings should occur at the point of first contact between a patient and the SUD system of care, whether via the Beneficiary Access Line (BAL) or at the treatment provider site. Medical necessity determinations, on the other hand, will occur at the provider site and must occur within fifteen (15) calendar days of treatment admission. Treatment providers should verify initial DMC-ODS eligibility and insurance status prior to the provision of services. For patients who are determined to be eligible for Medi-Cal but not enrolled, treatment providers must make efforts to enroll patients and facilitate the enrollment process.

The initial DMC eligibility verification may be performed by trained support staff and/or registered or certified SUD counselors, however medical necessity determinations must be verified by a Medical Director, licensed physician, or Licensed Practitioner of the Health Arts (LPHA): physician, registered nurse, nurse practitioner, physician assistant, licensed/waivered psychologist, licensed/waivered/registered social worker, licensed/waivered/registered marriage and family therapist, licensed/waivered/registered Licensed Professional Clinical Counselor. Verification of medical necessity by an LPHA must occur via a face-to-face or telehealth review with the individual conducting the assessment (e.g., SUD counselor).

Ongoing DMC eligibility verification will be determined by medical necessity assessment at least every six (6) months through the reauthorization process for all SUD services other than Opioid Treatment Program services, which require DMC verification every twelve (12) months. During the reauthorization process, the Medical Director, licensed physician, or LPHA at the provider agency will be required to justify ongoing eligibility for services by requesting DMC eligibility verification and submitting clinical documentation including current treatment plan, assessment information, progress notes, and laboratory test results (if available).

Utilization Management staff will review clinical cases for SUD care provided within SAPC network, including both adolescent and adult patients. The purpose of these case reviews is to establish an ongoing monitoring program to ensure appropriate and quality care, patient safety, and appropriate utilization of services across the SUD service continuum.

Adult and youth cases at each ASAM level of care will be randomly and retrospectively reviewed on at least an annual basis, in addition to the cases that require authorization and preauthorization (described below). These case reviews are independent from SAPC contract monitoring activities and the quantity of these reviews will occur at County discretion. The purpose of these retrospective reviews is to support the UM program, ensure high quality care, patient safety, and prevent and minimize fraud, waste, and abuse.

Utilization Management staff may also conduct focused, retrospective chart reviews whenever concerns arise about a particular provider or patient. Such reviews may be conducted on site or electronically and without prior notice to the provider. As needed, UM and Contracts staff will confer on cases to determine the most appropriate responding SAPC entity, whether it be qualified clinical staff from the UM Unit (physicians, nurses, psychologists, or social workers), or contract monitoring staff within the Contracts Unit. These cases will then be addressed, as appropriate.

The following methods of review are utilized by UM staff:

- ***Prospective Review*** - A prospective review occurs prior to the delivery of services (e.g., preauthorization for residential treatment services).
- ***Concurrent Review*** - A concurrent review examines ongoing care to evaluate medical necessity, and the quality and appropriateness of care (e.g., authorization for Medication-Assisted Treatment for youth or Recovery Bridge Housing, or reauthorization of ongoing residential treatment services).
- ***Retrospective Review*** – A retrospective review examines various aspects of previously provided services (e.g., random review of adult and youth cases within all ASAM levels of care).

<u>Preauthorization</u>

Services requiring preauthorization are services for which the treating provider must request authorization before initiating treatment and/or before continuing care for an extension of a previous

authorization, unless providers elect to provide the service prior to receiving preauthorization and accept potential financial loss if the preauthorization is ultimately denied. In these instances, UM staff will perform prospective reviews of care that has yet to be provided and concurrent reviews of extensions of previous authorizations, when pertinent. Clinical scenarios that require preauthorization include:

- Residential services (refer to the Clinical Case Review Process section below for more details)
    - Residential preauthorizations pertain to the provision of all residential services, including youth, adults, perinatal patients, and criminal justice involved patients.
    - Residential preauthorizations are only required when initiating residential care or transitioning from non-residential to residential levels of care. For transitions between residential levels of care (e.g., either transitions up or down between residential levels), a notification to SAPC, rather than a residential reauthorization, is required.
    - Residential services require reauthorization after sixty (60) calendar days for all adult populations and after thirty (30) days for youth in order to assess for appropriate level of care utilization.

<u>Authorization</u>

Authorized services are services that require authorization from SAPC, but do not require authorization prior to the provision of services. In these instances, UM staff will perform concurrent reviews of care and extensions of previous authorizations, when pertinent. Clinical scenarios that require authorization include:

- Medication-Assisted Treatments for youth under age 18 (refer to relevant sections below for more details)
- Withdrawal management for youth under age 18
    - For youth, withdrawal management (WM) is not an ASAM level of care and is therefore not included in the DMC-ODS youth benefit package. However, WM may be approved for youth on a case-by-case basis via an authorization process if determined to be medically necessary, and may be integrated with services in other settings.
    - When WM for youth involves medication-assisted treatment (MAT), MAT for youth under age 18 requires authorization.
- Recovery Bridge Housing (RBH)
    - SAPC may authorize RBH for *adults* who meet <u>all</u> of the following criteria:
        - In need of a stable, safe living environment in order to best support their recovery from a SUD.
        - Belongs to one of the prioritized populations (see Table 12 for more details).
        - Concurrently enrolled in treatment in Outpatient (OP), Intensive Outpatient (IOP), Opioid Treatment Program (OTP), or Outpatient (aka: Ambulatory) Withdrawal Management (OP-WM) settings.

If after careful consideration of all case information UM staff determine that the proposed and provided services are necessary, appropriate, and in accordance with standards of clinical practice outlined in the Quality Improvement program, services and reimbursement will be authorized. UM staff are qualified clinicians with appropriate clinical expertise in the treatment of SUDs.

Utilization decisions will be based on sound, evidence-based guidelines. Denials of authorization or appeal will be reviewed by supervisorial staff within the UM program who were not involved in any previous level of review in the respective cases.

Denials of authorization will result in denial of reimbursement for services rendered.

Denial notifications will consist of information including, but not limited to:
- The action SAPC or its contracted provider has taken and/or intends to take.
- The reasons for the action.
- The party's right to file a grievance or appeal with SAPC.
- The patient's right of a fair hearing.
- The procedures for exercising their rights.
- The circumstances under which expedited resolution is available and how to request it.
- The patient's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the patient may be required to pay the costs of the services.
- Any additional information needed to improve or complete the claim.

The purpose of this Executive Summary is to provide a brief overview of the QI and UM Manual. Please refer to the full QI and UM Manual for additional details.

OVERVIEW

The Substance Abuse Prevention and Control (SAPC) is a division of the Los Angeles County Department of Public Health, and is responsible for leading and facilitating the delivery of a full spectrum of prevention, treatment, and recovery support services for substance use disorders (SUD) and addiction across Los Angeles County.

Key organizational objectives are to develop a comprehensive, coordinated, and integrated continuum of care for the treatment of SUD that is accessible, evidence-based, effective, and sustainable. The QI and UM programs help to achieve these aims by providing a systematic method to oversee the quality and appropriate utilization of substance use services in Los Angeles County, and support providers in delivering timely, clinically necessary and evidence-based care.

The QM program is closely interwoven with the UM program to ensure that functions, data, information, decisions, policies, and procedures of one program are aligned and coordinated with the other to assure comprehensive oversight and tight quality control within the SAPC network of providers.

This manual describes the goals, scope, structure and operations of the SAPC QI and UM programs, and pertains to all providers who provide services within the SAPC network of care throughout Los Angeles County.

The QI and UM programs set standards in areas including medical necessity criteria, clinical practice, and level of care guidelines, founded on criteria established by the American Society of Addiction Medicine (ASAM).

The UM program helps to ensure quality services by monitoring adherence to the guidelines established in the QI and UM programs, including processes involving verification of DMC benefits and medical necessity criteria, as well as appropriate clinical care and level of care utilization.

Scope

The SAPC QI and UM Manual establishes a framework for oversight that encompasses all clinical services, utilization management, and review of safety/risk management data. The QI and UM programs share complementary goals of ensuring that SUD treatment is accessible, quality-focused, evidence-based, timely, and appropriate. This objective is achieved through the routine and ongoing monitoring and evaluation of SAPC's network of providers. The continuum of SUD care provided includes: prevention, outpatient services, intensive outpatient services, residential services, withdrawal management services, and Opioid Treatment Programs (OTP). Provided services include psychosocial interventions, counseling, medication-assisted treatments, case management, care coordination, perinatal and postpartum services, physician consultation, and recovery support services.

The purpose of the QI program is to set standards in areas including medical necessity criteria, clinical practice, and level of care guidelines, founded on criteria established by the American Society of Addiction Medicine (ASAM).

Additional elements of the QI program includes conducting performance improvement projects, submitting performance measurement data to the State, having mechanisms to detect under- and over-utilization of services, assess the quality and appropriateness of care furnished to patients with special health care needs, implementing a grievance and appeals process, and establishing guidelines for confidentiality and risk management, including ensuring service/billing integrity. Importantly, the QI

program outlines a minimum standard and should not be construed as encompassing the totality of comprehensive SUD care provision.

Similarly, the UM program helps to ensure quality services by monitoring adherence to the guidelines established in the QI program, including processes involving verification of DMC eligibility and medical necessity criteria, as well as appropriate clinical care and level of care utilization. Additionally, the UM program works with the SAPC Research and Evaluation Unit to collect, maintain, and evaluate accessibility of care and waiting list information.

The SAPC QI and UM programs pertain to all SUD services provided within SAPC's network of providers, and strives to work collaboratively with community providers and stakeholders, while complying with state and federal regulations and guidelines.

Given the continual evolution of the field of addiction treatment, the QI and UM Manual is a living document and will evolve with the availability of new information and research, or changes in regulatory mandates or contractual agreements. As a result, this document is subject to ongoing review and revision.

Key Objectives

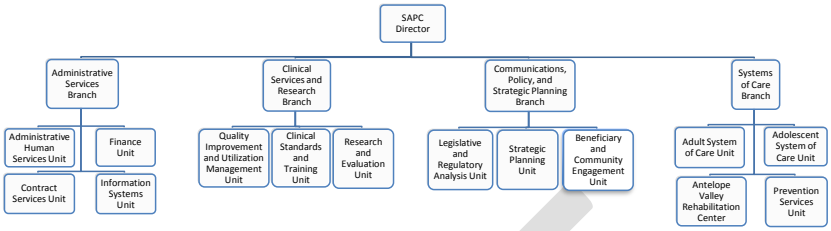
The broad objective of the QI and UM programs are for patients receiving SUD services to receive effective, coordinated care that is the right service provided at the right time, at the right intensity, and for the appropriate duration. Key objectives include:

- Support providers to help patients achieve recovery, stability, and functional improvement.
- Ensure timely access to high quality, evidence-based, medically necessary SUD services in the most appropriate setting.
- Ensure effective and efficient utilization of SUD services and resources.
- Facilitate and coordinate care between physical health, mental health, and SUD services.
- Ensure the provision of services that are age-specific and developmentally, culturally, and linguistically appropriate.
- Involve patient support systems (e.g., family members, significant others), when clinically appropriate.
- Monitor and analyze clinical performance and outcome measures to identify and promote opportunities to improve service delivery, patient outcomes, and overall organizational and provider performance.

Program Staff Structure

The SAPC QI and UM Unit is overseen by the SAPC Medical Director and Science Officer, and is multidisciplinary staff that carry out their responsibilities as defined by the scope of practice of their individual professional disciplines and assigned job descriptions. Various branches within SAPC provide essential support, including the branches of Administrative Services (including Contracts, Finance, and Information Technology), Clinical Services and Research, Communications, Policy and Strategic Planning, and Systems of Care (Adult, Youth, Prevention).

SAPC Organizational Structure

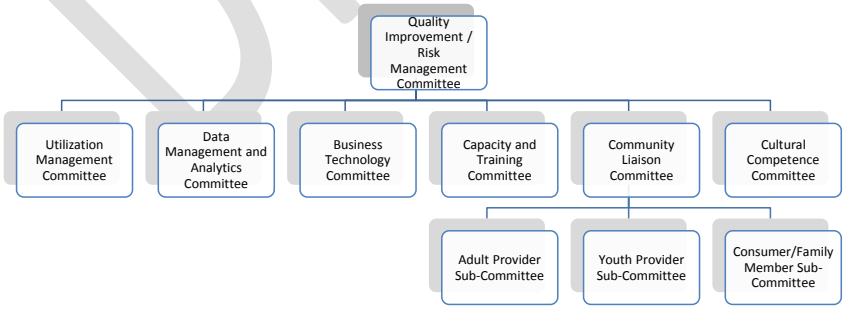


Committee Structure

A committee structure within SAPC provides a framework for the quality improvement and oversight responsibilities the organization. As such, the majority of committees are internal and attended by SAPC branch representatives and relevant parties. However, there are two committees that include external stakeholders such as providers, consumers, and families, among others.

The standing committees are listed below, followed by more detailed information:

- Quality Improvement / Risk Management Committee
- Utilization Management Committee
- Data Management and Analytics Committee
- Business Technology Committee
- Capacity and Training Committee
- Community Liaison Committee (comprised of various Sub-Committees)
- Cultural Competence Committee



Quality Improvement / Risk Management Committee

- The Quality Improvement / Risk Management Committee will serve as the lead committee that will be responsible for ensuring quality-focused services and that SAPC is positioned to achieve its organizational mission.
- Roles and Function:
    - Ensure patient safety and satisfaction, quality of care, and organizational efficiencies.
    - Recommend policy decisions.
    - Institute needed QI actions.
    - Ensure follow-up of QI processes.
    - Review and evaluate the result of QI activities.
    - Document minutes regarding decisions and actions taken.
    - Review and update as necessary the medical necessity criteria and Clinical Practice Guidelines annually.
    - Review and monitor clinical performance indicators across all provider sites, including accessibility of services.
    - Review and approve all new provider quality improvement projects (QIPs), as needed.
    - Quarterly review of the following data:
        - Number of days to first DMC-ODS service at appropriate level of care after referral.
        - Existence of a 24/7 access line with prevalent non-English languages.
        - Access to DMC-ODS services with translation services in the prevalent non-English languages.
        - Number and percent of denied claims, and time period of authorization requests, approved or denied.
        - Data required by External Quality Review Organization (EQRO) process.
    - Oversee annual formal evaluation of QI and UM programs.
    - Review targeted clinical records, complaint/grievance and appeals filed by patients, their representatives, and/or providers.
    - Designated SAPC staff will ensure a tracking and documentation system for all reportable incidents (defined as a patient safety event that results in death, permanent harm, and/or severe temporary harm and intervention required to sustain life), conduct investigations, and implement and follow up on corrective actions, as appropriate.
    - Oversee and monitor compliance with the applicable legal and regulatory obligations that pertain to activities performed by the SAPC QI and UM programs.
    - Identify opportunities to improve compliance and risk management processes.
    - Identify opportunities to improve QI and UM processes and support other organizational functions.
    - Collaborate with relevant internal and external committees and parties to design, implement, and ensure feasible measurement of interventions for improving quality, care and performance.
    - Provide support to other departmental and organizational functions, as needed.
- Lead SAPC branch: Clinical Services and Research
- Involved SAPC departments and stakeholders: Director's Office, Clinical Services and Research, Systems of Care (Adult, Youth, and Prevention), Contract Services, Policy/Strategic Planning/Communications, Information Systems, Finance.
- Meeting Frequency: Minimum every other month.

A structure of standing committees will establish an organized framework to ensure quality both within SAPC and its network of providers. Relevant information from these committees will flow to the Quality Improvement / Risk Management Committee, which will be the lead committee responsible for ensuring quality-focused services and that SAPC is in a position to achieve its organizational mission.

Utilization Management Committee

- Roles and Function:
  - On at least an annual basis, evaluate the consistency with which health care professionals involved in UM apply utilization decision-making criteria and review process used to approve the provision of services.
  - Evaluate consistent provision of services in accordance with clinical standards described in QI and UM Manual.
  - Review process of UM authorization decisions and determining appropriate services, and ensure that UM staff have the appropriate training and clinical skillsets to render these decisions.
  - Review initial and ongoing DMC eligibility verification, and initial and continued service authorization decisions.
  - Identify and monitor under-utilization and over-utilization of services.
  - Identify and monitor utilization patterns that:
    - Compromise enrollee health and safety.
    - Inappropriately use resources.
    - Result in clinical or organizational risk.
  - Oversee annual formal evaluation of UM program.
  - Identify opportunities to improve UM processes and support quality improvement activities.
  - Provide support to other departmental and organizational functions, as needed.
  - Perform special targeted monitoring activities, as required by regional need or regulatory mandate.
- Lead SAPC branch: Clinical Services and Research
- Involved SAPC branches and stakeholders: Clinical Services and Research, Systems of Care (Adult, Youth, and Prevention), Contract Services, Information Systems, Finance.
- Meeting Frequency: Minimum quarterly.

Data Management and Analytics Committee

- Roles and Function:
  - Review process of data collection and management to ensure security, effectiveness, and efficiency.
  - Collect and analyze data to ensure that data collection aligns with and informs organizational goals and priority areas of improvement.
  - Monitor accessibility of services:
    - Timeliness of first initial contact to face-to-face appointment.
    - Timeliness of services of the first dose of NTP services.
    - Access to after-hours care.
    - Responsiveness of the Beneficiary Access Line.
    - Coordination of physical and mental health services.
    - Assessment of the patients' experiences.
    - Telephone access line and services in the prevalent non-English language.
  - Identify opportunities to improve data management processes and support quality improvement activities, including the consideration of new technologies.
  - Provide guidance on quality-focused research priorities and projects.
  - Support Utilization Management Committee in performing special targeted monitoring activities related to data acquisition, as required by regional need or regulatory mandate.
  - Provide support to other departmental and organizational functions, as needed.

- Lead SAPC branch: Clinical Services and Research
- Involved SAPC branches and stakeholders: Clinical Services and Research, Systems of Care (Adult, Youth, and Prevention), Information Systems, Policy/Strategic Planning/Communications, UCLA-ISAP.
- Meeting Frequency: Minimum quarterly.

Business Technology Committee

- Roles and Function:
    - Oversee and manage information technology (IT) related business strategies, projects, and processes to ensure quality, effectiveness, efficiency, security, and overall alignment with SAPC mission and objectives.
    - Oversee implementation, operation, and governance of SAPC's electronic information system.
    - Ensure that SAPC and providers have sufficient training to effectively utilize SAPC's electronic information system and other IT-related business technologies.
    - Ensure that established standards, rules, and applications are effectively maintained to support clinical and administrative data exchange with health information exchanges (HIEs) and various electronic health records (EHR).
    - Identify opportunities to improve IT-related business strategies, projects, and processes, including the consideration of new technologies.
    - Assess new technologies, trends, applications and systems that relate to or affect SAPC's IT business strategy or programs.
    - Periodically review IT risks and risk management strategies, including disaster recovery capabilities.
    - Make recommendations to SAPC leadership with respect to IT-related business strategies, projects, and investments.
    - Provide support to other departmental and organizational functions, as needed.
- Lead SAPC branch: Information Systems
- Involved SAPC branches and stakeholders: Clinical Services and Research, Systems of Care (Adult, Youth, and Prevention), Contract Services, Policy/Strategic Planning/Communications, Finance.
- Meeting Frequency: Minimum quarterly.

Capacity and Training Committee

- Roles and Function:
    - Identify capacity and training needs of SAPC staff and provider network, based on issues and developments in the field of addiction care.
    - Review and implement educational processes to ensure continued professional development of SAPC staff, and ongoing training for SAPC providers.
    - Collaborate with Cultural Competence Committee regarding issues with cultural competency.
    - Collaborate with Community Liaison Committee regarding stakeholder input and concerns.
    - Provide support to other departmental and organizational functions, as needed.
- Lead SAPC branch: Policy/Strategic Planning/Communications
- Involved SAPC branches and stakeholders: Clinical Services and Research, Systems of Care (Adult, Youth, and Prevention), Contract Services, Policy/Strategic Planning/Communications, Information Systems, Finance.
- Meeting Frequency: Minimum quarterly.

Community Liaison Committee

- The Community Liaison Committee will consist of an adult provider sub-committee, a youth provider sub-committee, as well as a consumer/family member sub-committee.
- **Adult Provider Sub-Committee**: Consists of the various provider meetings that are currently established (e.g., All Providers' Meeting, Los Angeles County Evaluation System [LACES] Advisory Workgroup meeting, Opioid Treatment Program meeting, CAADPE [California Association of Alcohol and Drug Program Executives] meeting, etc).
- **Youth Provider Sub-Committee**: Consists of quarterly Youth Provider meeting, etc.
- **Consumer/Family Member Sub-Committee**: Consists of consumer and family member stakeholders; will meet on a quarterly basis in rotating Service Planning Areas of the County.
- Roles and Function:
    - Promote stakeholder (consumers, families, providers, and Commission on Alcohol and Other Drugs, etc.) collaboration regarding the QI and UM process and SUD performance measures, including feedback, addressing transparency, concerns, and ideas for future projects.
    - Report stakeholder feedback, knowledge, and suggestions to departmental and organizational leadership, as well as pertinent Committees (e.g., Capacity and Training Committee, Cultural Competence Committee).
    - Provide support to other departmental and organizational functions, as needed.
- Lead SAPC branch: Systems of Care
- Involved SAPC branches and stakeholders: Clinical Services and Research, Systems of Care (Adult, Youth, and Prevention), Contract Services, Policy/Strategic Planning/Communications, Information Systems, UCLA-ISAP, relevant stakeholders (see above).
- Meeting Frequency: Variable, depending on need.

Cultural Competence Committee
- Roles and Function:
    - Review and evaluate cultural competency of services provided to patients and their families.
    - Collaborate with the QI/RM and UM Committees to promote cultural awareness and sensitivity.
    - Identify opportunities to improve cultural competence within QI and UM processes.
    - Collaborate with the Capacity and Training Committee and Community Liaison Committee around issues with cultural competency.
    - Provide support to other departmental and organizational functions, as needed.
- Lead SAPC branch: Clinical Services and Research
- Involved SAPC branches and stakeholders: Clinical Services and Research, Systems of Care (Adult, Youth, and Prevention), Contract Services, Policy/Strategic Planning/Communications, relevant stakeholder groups identified in the Community Liaison Committee. As needed: Finance and other subject matter experts.
- Meeting Frequency: Minimum quarterly.

Table 1. Committee Structure Summary

Committee	Function	SAPC Lead	Minimum Meeting Frequency
Quality Improvement/Risk Management*	Identify opportunities to improve quality of services, compliance and risk management, review documents (records, complaints/grievances, appeals), ensure	CSR	Every other month

Committee	Function	SAPC Lead	Minimum Meeting Frequency
	collaboration and information exchange, and support provider-level quality improvement.		
Utilization Management	Evaluate use of medical necessity, provision of services, review initial / ongoing DMC eligibility, identify and monitor over/under utilization of services and risk patterns.	CSR	Quarterly
Data Management and Analytics	Provide guidance on research priorities, identify opportunities to improve data management, support quality improvement, and consider new technologies.	CSR	Quarterly
Business Technology	Oversee and manage IT-related strategies, projects, and processes to ensure alignment with SAPC mission and objectives.	Information Systems	Quarterly
Capacity and Training	Identify capacity and training needs of SAPC staff and providers, ensure continued professional development and collaboration with other committees.	Policy/Strategic Planning/ Communications	Quarterly
Community Liaison (Adult, Youth, and Consumer/Family Member)**	Promote stakeholder collaboration regarding SAPC programming and processes, including the QI and UM process and SUD performance measures. Report stakeholder feedback, knowledge, and suggestions to departmental and organizational leadership.	Systems of Care	Variable
Cultural Competence**	Evaluate cultural competency and identify opportunities to improve cultural competence of services provided to patients and their families; and promote cultural awareness and sensitivity.	CSR	Quarterly

** Quality Improvement / Risk Management Committee serves as lead committee*
*** The Community Liaison Committee and Cultural Competence Committee will include external stakeholders such as providers, consumers, and families, among others*

CSR – Clinical Services and Research
PSPC – Policy/Strategic Planning/Communications
SAPC – Substance Abuse Prevention and Control
UCLA-ISAP – University of California Los Angeles, Integrated Substance Abuse Programs

QUALITY IMPROVEMENT PROGRAM

The Quality Improvement and Utilization Management Programs applies to all providers and patients, regardless of funding stream or modality of treatment.

Quality improvement activities help to ensure accessible, quality-focused, evidence-based, effective, and appropriate SUD treatment services. The purpose of the QI program is to assess performance against best practice guidelines to ensure that SUD services follow generally accepted standards of clinical practice in terms of medical necessity, clinical practice, and level of care guidelines, and to continuously improve SUD service delivery. As such, the QI program aligns with SAPC's organizational mission and goals, and strives to support the SAPC provider network in the provision of quality care and maintain programmatic, clinical, and fiscal integrity to adapt to a changing health care landscape.

The QI program conducts ongoing performance improvement projects that focus on clinical and nonclinical areas, involving:

- Implementation of system interventions to achieve quality improvement.

- Measurement of performance using objective quality indicators.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

These projects are designed to achieve, through ongoing measurements and intervention, significant and sustained improvement in clinical care and nonclinical areas that are expected to have a favorable effect on health outcomes and client satisfaction.

The QI program will implement a multi-model approach in order to achieve its objectives by utilizing the following two models: 1) Continuous Quality Improvement Model (CQI), and 2) the Chronic Care Model (CCM).

Continuous Quality Improvement

The CQI and UM model is a respected quality improvement model that can be employed within a behavioral health setting (see Figure 1).

Figure 1. Continuous Quality Improvement (CQI) Framework

The CQI model is based on concepts of quality improvement and performance measurement, and employs a patient-centered philosophy and long-term approach to provide tools to help quantify what a system should do. Additionally, this model investigates common causes for variation within a system and is driven by data, process, and patient feedback. As a result, SAPC will continue to work with providers to monitor performance and outcomes as part of the CQI process (see Performance and Outcome Measures below). The CQI model is very similar to other cyclical approaches utilized in Public

Health (Planning, Implementation, Evaluation, and Review) and is based off earlier quality improvement models of "Plan-Do-Study-Act" activities.

The six steps of CQI are defined in Table 2.

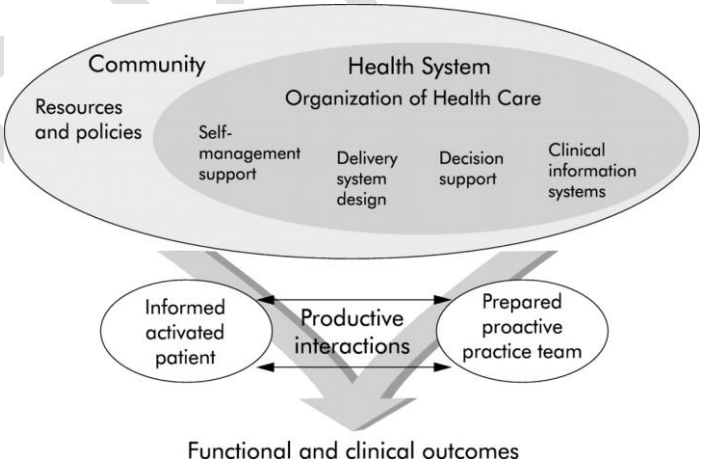
Table 2. Six Steps of Continuous Quality Improvement

1. **Identify** a need/issue/problem and develop a problem statement.
2. **Define the current situation -** Break down problem into component parts, identify major problem areas, develop a target improvement goal.
3. **Analyze the problem -** Identify the root causes of the problem and consider using visuals, as needed.
4. **Develop an action plan -** Outline ways to correct the root causes of the problem and specific actions to be taken.
5. **Look at the results -** Confirm that the problem and its root causes have decreased or resolved and identify if the target has been met
6. **Start over -** Repeat process for the additional identified problems.

Chronic Care Model

Another model that lends itself well to quality improvement in behavioral health is Wagner's "Chronic Care Model" (CCM; see Figure 2).

Figure 2. Chronic Care Model (CCM)



The CCM identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery

system design, decision support and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. These components are described in greater detail in Table 3.

Table 3. Components of the Chronic Care Model

1. ***Health Systems:*** Create a culture, organization and mechanisms that promote safe, high quality care.
   - Visibly support improvement at all levels of the organization, beginning with the senior leader
   - Promote effective improvement strategies aimed at comprehensive system change
   - Encourage open and systematic handling of errors and quality problems to improve care (2003 update)
   - Provide incentives based on quality of care
   - Develop agreements that facilitate care coordination within and across organizations (2003 update)
2. ***Delivery System Design:*** Assure the delivery of effective, efficient clinical care and self-management support
   - Define roles and distribute tasks among team members
   - Use planned interactions to support evidence-based care
   - Provide clinical case management services for complex patients
   - Ensure regular follow-up by the care team
   - Give care that patients understand and that fits with their cultural background
3. ***Decision Support:*** Promote clinical care that is consistent with scientific evidence and patient preferences
   - Embed evidence-based guidelines into daily clinical practice
   - Share evidence-based guidelines and information with patients to encourage their participation
   - Use proven provider education methods
   - Integrate specialist expertise and primary care
4. ***Clinical Information Systems:*** Organize patient and population data to facilitate efficient and effective care
   - Provide timely reminders for providers and patients
   - Identify relevant subpopulations for proactive care
   - Facilitate individual patient care planning
   - Share information with patients and providers to coordinate care
   - Monitor performance of practice team and care system
5. ***Self-Management Support:*** Empower and prepare patients to manage their health and health care
   - Emphasize the patient's central role in managing their health
   - Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
   - Organize internal and community resources to provide ongoing self-management support to patients
6. ***The Community:*** Mobilize community resources to meet needs of patients
   - Encourage patients to participate in effective community programs
   - Form partnerships with community organizations to support and develop interventions that fill gaps in needed services
   - Advocate for policies to improve patient care

Source: http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18

Effective care of chronic conditions, such as SUD, is characterized by productive interactions between activated patients, as well as their family and caregivers, and a prepared practice team. This care takes place in a health care system that utilizes community resources.

At the level of clinical practice, four areas influence the ability to deliver effective chronic illness care: 1) self-management support (empower and prepare patients to manage their health and health care), 2) delivery system design (assure the delivery of effective, efficient clinical care and self-management support), 3) decision support (promote clinical care that is consistent with scientific evidence and patient preferences), and 4) clinical information systems (organize patient and population data to

facilitate efficient and effective care). The end goal is to deliver care that is safe, effective, timely, patient-centered, efficient and equitable.

Access to Care

Access to care refers to the psychosocial and physical access to the location where treatment services are rendered. Physical barriers may include the architecture of the site, such as treatment providers with steps but no ramp entrance, or environmental barriers such as program location in an area where patients do not feel safe. Lack of soundproofing in counseling offices and lack of privacy in assessment rooms are also potential barriers. Psychosocial barriers may include lack of communication capabilities for hearing- or visually-impaired individuals, attitudes expressed by counselors or other staff that denote biases or communicate stigma to the patients, lack of a diverse workforce, operational hours that restrict access to services, or a lack of opportunity for patient input into his or her treatment plan or program operations. One of the central goals of SAPC is to ensure that access to SUD treatment is timely, broad, and evidence-based.

Referrals for substance use disorder (SUD) care may include SUD providers or the nearest emergency room, in cases deemed to be medical or psychiatric emergencies.

Access to Timely Services

Patients can access SUD services by calling the Beneficiary Access Line (BAL) or contacting the provider directly. The BAL is available 24 hours a day, seven (7) days a week. Patients can call the BAL to initiate a self-referral for treatment. Patients can also be referred by an organization or others, including but not limited to, physical and mental health providers, law enforcement, family members, schools, and County departments. The BAL will be capable of providing referrals to programs that specialize in treating special populations or specific cultural groups. It will also have access to additional culture-based services such as interpretation services and services for the hearing and visually impaired.

Staff at the BAL will conduct a provisional DMC eligibility verification and clinical triage assessment for youth and adults via phone in order to determine the most appropriate referral.

The BAL will set the appointment for the initial assessment/intake with the selected provider while the beneficiary is on the call except under limited circumstances (e.g., the caller is unable to schedule, the automated appointment system is not yet developed/not working), but no longer than three (3) business days from the date of the brief triage assessment. Unless the beneficiary has specific provider or other preferences (e.g., cultural/linguistic specific services) that would require a longer waiting period, the assessment/intake appointment with a qualified SUD network provider that is geographically accessible will be conducted within established timeframes from the date of the brief triage assessment (see Table 4).

Patients who need SUD care must be scheduled for an appointment within three (3) business days of their brief triage assessment and receive an intake appointment with their treatment provider within five (5) business days in outpatient settings and ten (10) business days in residential settings. These timeframe targets will shorten to five (5) business days in all treatment levels of care in future years.

Table 4. SAPC Access Standards

Description	Access Standard
Appointment scheduled	Immediately, but no later than 3 business days after brief triage assessment
Intake date with SUD provider *(starting July 2017)*	- Within five (5) business days from date of brief triage assessment in outpatient settings - Within ten (10) business days from date of brief triage assessment in residential settings
Intake date with SUD provider *(starting July 2018)*	Within five (5) business days from date of brief triage assessment in all treatment levels of care
Distance	Every effort must be made to refer patients to a treatment program within: - Thirty (30) minutes of travel time by personal or public transportation; OR - Ten (10) miles from the patients' location of choice

For individuals that present at the provider site first, the same timeliness and culture-based service expectations apply and alternate referrals should be offered and documented if this cannot be achieved before placing the individual on a waitlist. Expedited or other suitable/appropriate accommodations for scheduling appointments will be made for urgent situations whenever possible. SAPC will regularly evaluate timely receipt of services, including seeking service expansion to improve the ability to receive services upon demand.

Referrals may include SUD providers or the nearest emergency room, in cases deemed to be medical or psychiatric emergencies. If referred to an SUD provider, the referral would be based off patient preference after being given various options of available providers, as well as the preliminary appropriate level of care determination.

Screening and assessment processes may occur in person, over the phone, or via telehealth. The intensity of the screening and assessment process would correspond to the clinical need, and not be so intensive that the time required for the process becomes burdensome for the patient seeking services or the SUD program providing services. Furthermore, every effort should be made to minimize the elapsed time between the initial verification of DMC eligibility, clinical need determination, and referral, and the first face-to-face clinical appointment.

Every effort must be made to refer patients to a treatment program within:
- Thirty (30) minutes of travel time by personal or public transportation
  OR
- Ten (10) miles from the patients' location of choice

Research indicates that travel distance is linked to patient outcomes. As such, unless otherwise requested by the patient, every effort must be made to refer the patient to a treatment program that is within thirty (30) minutes of travel time by personal or public transportation or ten (10) miles from the patients' location of choice (see Table 4). If this is not feasible, every effort should be made to decrease the likelihood that the commute or transportation issues serve as a barrier to care. If patients prefer to have some aspect of treatment delivered in a different region than where they reside or work, this preference should be noted in their clinical record.

In cases where the preliminary level of care recommendation is residential treatment but residential beds are not available, the patient should be referred to another provider agency that does have residential bed availability. In some cases, for example if no residential beds can be located, it may be

appropriate to refer clients to the next most appropriate level of care with a warm hand-off to the most appropriate level of care once it is available.

As a means to optimize access to SUD services, providers need to implement an ongoing evaluation process in order to identify barriers to treatment that may relate to the physical or psychosocial access issues mentioned above, counselor/staff attitudes around substance use, patient transportation, or any other accessibility issues. This includes considering patient and stakeholder feedback during this process to ensure adequate access to care. Once barriers are identified, providers would develop a plan detailing how they plan on addressing the identified barriers. The plan would also specify the barrier(s), the action(s) that will be taken to eliminate or reduce the impact of the barrier, and when these specific actions will be completed.

Access to Array of Services

Patients will have access to all levels of care and services offered within the DMC-ODS benefits package, including outpatient, intensive outpatient, and residential treatment, withdrawal management (youth on a case-by-case basis), Opioid Treatment Program services, case management, Recovery Support Services, and Recovery Bridge Housing. SAPC will make every effort to ensure an adequate level of treatment providers for both adults and youth, based on utilization and community needs. Access to the different levels of care will be based on ASAM criteria. As patients move through the continuum of SUD care, appropriate placement will be reassessed at each transition in treatment modality in order to ensure that the patient is placed at the appropriate level of care. Additionally, providers are expected to perform clinical assessments to determine progress on a regular basis in order to transition patients to the next appropriate level of care as soon as clinically indicated.

Emergency Services and Post-Stabilization Care

Emergency medical and psychiatric conditions are defined as conditions with acute symptoms of sufficient severity that a prudent layperson could reasonably expect the absence of immediate care to result in placing health in serious jeopardy, serious impairment of functional status, or serious dysfunction of any bodily organ or part. All patients must have access to emergency and crisis care for their health condition, and must be referred to appropriate facilities for these services.

Preauthorizations or authorizations are not required for emergency services.

Post-stabilization care is provided after a patient is stabilized from an emergency health condition. The goal of post-stabilization care is to maintain the stabilized condition and improve the individual's health.

Access to Evidence-Based Services

When implemented appropriately and performed by qualified counselors and clinicians, evidence-based practices (EBP) have been proven to improve clinical care and outcomes. A number of psychosocial interventions and medication-assisted treatments are considered EBPs (see Psychosocial Interventions and Medication-Assisted Treatment sections below) and should form the foundation of a modern system for care for SUDs.

Providers are expected to provide a minimum of two psychosocial EBPs (i.e., motivational interview and cognitive-behavioral therapy) as a component of their treatment services, in addition to supporting the

use of medication-assisted treatments, when clinically appropriate. SAPC will continue to work with treatment providers to improve the quality of clinical services and provide access to trainings on evidence-based practices.

Access to Culturally Appropriate Services

Efforts must be made to provide culturally, linguistically, and developmentally appropriate services, including, but not limited to:

- Provide a provider list of services for special populations, such as young adults, veterans, older adults, LGBTQ, etc.
- Provide culturally, linguistically, and developmentally appropriate written information in threshold languages, including information on their rights to language assistance services.
- Work to expand capacity and ability to provide a broad range of culturally, linguistically, and developmentally appropriate services.

SAPC providers may call XXX-XXX-XXXX for language translation services.

Workforce

Recent changes in the field of addiction have led to substance use systems moving toward a chronic disease and public health model that requires a diverse, skilled, and highly trained workforce.

SAPC recognizes and values the contributions of contract providers of all sizes and capacities, and also realizes that the composition of a successful SUD system of care must reflect the diversity of needs of the population it serves. Subsequently, the provider workforce must be either composed of or have the capability to utilize the skills of multidisciplinary staff, all of whom are required to have appropriate experience and training at the time of hiring.

Professional clinical staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Licensed Practitioners of the Healing Arts (LPHA) include Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists (LCP), Licensed Clinical Social Workers (LCSW), Licensed Professional Clinical Counselors (LPCC), and Licensed Marriage and Family Therapists (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians. Other professional staff, such as SUD counselors, and non-professional staff, must receive appropriate on-site orientation and training prior to performing assigned duties, and need to be supervised by appropriately qualified staff. Registered and certified SUD counselors must also provide services within their scope of practice and adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8.

Licensed Practitioners of the Healing Arts (LPHA) include: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists (LCP), Licensed Clinical Social Workers (LCSW), Licensed Clinical Professional Counselors (LCPC), and Licensed Marriage and Family Therapists (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

Continuing education should be an integral component of professional development. SAPC will provide training support to enhance providers' capability to deliver evidence-based, quality care. In order to maintain standards of excellence in care, patient-to-counselor ratios should allow for adequate individualized attention to ensure quality care and appropriate follow-up.

Additionally, SAPC will explore opportunities to work with provider agencies to establish a career ladder for SUD counselors based on the Substance Abuse and Mental Health Services Administration (SAMHSA) "Scopes of Practice & Career Ladder for Substance Use Disorder Counseling." Each step on the ladder requires increasing levels of education and work experience, and increasing professional responsibility (e.g., clinical supervisors). By laying out a clear career path, with increases in pay and responsibility commensurate with each step, a career ladder can help establish professional standards for the field of specialty SUD treatment and retain a qualified workforce.

Documentation

Clinical documentation refers to anything in the patients' health record that describes the care provided to that patient, and its rationale. It is observational and narrative in content, and is written by counselors and clinicians to analyze the process and contents of patient encounters. Clinical documentation is a critical component of quality healthcare delivery and serves multiple purposes, helping to:

- **Ensure comprehensive and quality care –** The process of writing initial assessments and proper progress notes requires thought and reflection. Preparing proper clinical documentation serves an important role of helping assure quality patient care by giving practitioners an opportunity to think about their patients, review and reflect on their therapeutic interventions, consider the efficacy of their clinical work, and weigh alternative approaches to the care. Good clinical documentation helps one organize clinical details into a case formulation that can then be used for treatment planning and is an essential element of professional practice and of the provision of quality clinical services. It also helps to assure appropriate utilization of team members from multiple disciplines in order to leverage interdisciplinary competencies and maximize the quality of services provided.
- **Ensure an efficient way to organize and communicate with other providers –** The documentation of clinical care helps to provide structure and efficiencies to clinical communications with other providers who may be involved in the care of shared patients. This assures coordinated rather than fragmented treatment/service delivery.
- **Protect against risk and minimize liability –** Accurate and comprehensive clinical documentation is not only important in terms of quality care, but is also essential in risk management. Detailing and justifying the thought processes that contributed to the clinical decision-making process helps to support the adequacy of the clinical assessment, the appropriateness of the treatment/service plan, and demonstrates the application of professional skills and knowledge toward the provision of professional services.
- **Comply with legal, regulatory and institutional requirements –** Good clinical documentation practices help to assure compliance with recordkeeping requirements imposed by federal and state (including licensing boards) laws, regulations, and rules. It also helps to ensure that documentation meets the standards set by specific accreditation programs (e.g., CARF, Joint Commission), when applicable, and by health care institutions, facilities and agencies.
- **Facilitate quality improvement and application of utilization management –** Clinical documentation provides an opportunity to explain the process and substance of assessments, treatment and service planning, clinical decision-making, medical necessity, and the effectiveness of treatments and other services provided. As a result, it is essential for the utilization review process because clinical documentation helps to substantiate the need for further assessment, testing, treatment and/or other services, or to support changes in or termination of treatment and/or

services. From a quality perspective, clinical documentation facilitates supervision, consultation, and staff/professional development, and helps to improve the quality of services by identifying problems with service delivery by providing data based upon which effective preventative or corrective actions can be taken. Appropriate recordkeeping also provides data for use in planning educational and professional development activities, policy development, program planning and research in agency settings.

Clinical documentation must be credible and complete, and is protected via the Health Insurance Portability and Accountability Act (HIPAA) and Title 42, Code of Federal Regulations (42 CFR) Part 2. It encompasses every aspect of clinical care, including initial assessments, progress notes, and relevant encounters that occur outside of established appointments. Documentation of initial assessments follows the same format as the multidimensional ASAM assessment and reflects a comprehensive biopsychosocial approach. Progress notes are written during/after follow up appointments in order to gauge clinical progress and assess to determine if patient needs have changed and if modifications to the treatment approach/plan are required.

In general, clinical documentation includes the following characteristics:

- Notes that are dated, signed, and legible.
- Patient name and identifier are included on each page of the clinical record.
- Patient's race, ethnicity, and primary language spoken.
- Documented referral information.
- Sources of information are clearly documented.
- Patient strengths and limitations in achieving goals are noted and considered.
- The style of documentation is consistent and standardized throughout the agency/institution.
- The use of abbreviations is limited. However, when used, abbreviations are standardized and used in a consistent context.
- Documentation includes all relevant clinical information and reflects a biopsychosocial approach to the assessment process.
- Patient self-report of experiences and observed behavior is noted.
- Documentation reflects changes in patient status including response to and outcome(s) of the intervention(s) as well as progress towards goals and completion of objectives.
- Entries include the counselor's/clinician's professional assessment and continued plan of action.
- Changes in patient status are documented (e.g., change in level of care provided or discharge status).
- Describe how services provided reduced impairment, restored functioning, and/or prevented significant deterioration as outlined in the treatment plan.
- For patients with limited English proficiency, document if interpreter services were offered and provided, and an indication of the patient's response.

Treatment Plan *Review* and *Update* Minimum Standards

Outpatient, Intensive Outpatient, and Opioid Treatment Program settings:

- Treatment plan ***reviews*** at minimum every thirty (30) calendar days.
- Treatment plan ***updates*** at minimum every ninety (90) calendar days.

Residential settings:

- Treatment plan ***reviews*** at minimum every fifteen (15) calendar days.
- Treatment plan ***updates*** at minimum every thirty (30) calendar days.

Treatment Plans

Patient-centered care is critical and requires that patients be provided the opportunity to actively shape their treatment plans.

Table 5. Treatment Plan Minimum Requirements

Treatment Plan Activity	Level of Care	Minimum Requirement
Treatment Plan *Review*	Outpatient Intensive Outpatient Opioid Treatment Program	**Every thirty (30) calendar days, at minimum**
	Residential	**Every fifteen (15) calendar days, at minimum**
Treatment Plan *Update*	Outpatient Intensive Outpatient Opioid Treatment Program	**Every ninety (90) calendar days, at minimum**
	Residential	**Every thirty (30) calendar days, at minimum**

As patients advance through treatment, the corresponding treatment plan should be reviewed and updated accordingly based on stability and the likelihood of rapid changes in patient condition. Treatment plans should be updated more frequently if an individual is unstable or if there is a notable event that requires a change in the treatment plan. See Table 5 for additional detail regarding minimum requirements for treatment plan reviews and updates.

If a patient's condition does not show improvement at a given LOC or with a particular intervention, then a review, abbreviated assessment, and treatment plan modification should be made in order to improve therapeutic outcomes. Changing the level of care or intervention should be based on a reassessment and modification of the treatment plan in order to achieve an improved therapeutic response.

Treatment plans must meet the requirements specified in the AOD certification standards, Title 22, CCR, Section 51341.1 (h)(2)(A), or for Opioid Treatment Programs, Title 9, CCR, Section 10305, as specified in Title 22, CCR, Section 51341.1(h)(2)(B). At a minimum, treatment plans should include:

- Thorough documentation of case details, including a diagnosis and statement of problems to be addressed.
- Goals that are mutually established between patient and provider for each identified problem.
- Action steps to be taken by the provider and/or patient in order to achieve the identified goals.
- Target dates for the achievement of identified action steps and goals.
- Description of the type(s) and frequency of services to be provided.
- Required documentation, as specified in Titles 9 and 22, including documentation of physical examinations.
- The patient shall review, approve, type or legibly print their name, sign and date the initial treatment plan, indicating whether the patient participated in preparation of the plan, within thirty (30) calendar days of signature by the counselor or provider. If the patient refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the patient to participate in treatment.
- If the LPHA determines the services in the updated treatment plan are medically necessary, the LPHA shall type or legibly print their name and, sign and date the updated treatment plan, within fifteen (15) calendar days of signature by the counselor or provider.

Standardized documentation (e.g., SOAP, GIRP, SIRP, or BIRP) increases treatment consistency, quality of care and reduces reimbursement disallowances. SAPC requires that initial documentation be based on the format of the ASAM criteria, and that progress notes for individual and group sessions follow either the SOAP, GIRP, SIRP, or BIRP formats.

Importantly, when medications are included in the treatment plan, LPHAs who sign off on treatment plans must be licensed prescribers, whether in the opioid treatment program (OTP) setting or non-OTP settings.

Progress Notes

For level of care transitions, initial and relevant progress note documentation are based on the ASAM criteria and include the following information:

- Date ASAM placement criteria were used.
- Documentation of the name, location and primary contact at referral site.
- Format of ASAM criteria used (software or paper-based).
- Justification of discrepancy if the level of care suggested by ASAM criteria is not recommended by counselor/clinician.
- Justification of discrepancy if the discussed level of care is not agreeable to patient.
- Justification of discrepancy if the level of care the patient was referred to does not match the level of care suggested by the ASAM criteria.

Progress notes must, at a minimum, be documented each day there is a patient encounter in outpatient and intensive outpatient settings. In residential settings, progress notes must be documented at least weekly by staff that have provided services for the patient during that time period.

Standardized documentation by SUD counselors and clinicians assist with increasing treatment consistency and quality of care, as well as reducing reimbursement disallowances. As such, SAPC requires that the multidimensional components of the ASAM criteria be incorporated into initial documentation of the first full assessment, and that progress notes for both individual and group sessions follow one of four formats: SOAP, GIRP, SIRP, or BIRP.

SOAP (Subjective, Objective, Assessment and Plan) is an acronym that describes the structure of a specific style of progress note documentation. The SOAP format is widely used and improves the quality and continuity of patient services by providing a consistent and organized framework of clinical documentation to enhance communication among health care professionals and better recall the details of each patient's case. This format allows providers to identify, prioritize and track patient problems so they can attend to them in a timely and systematic manner. It also provides an ongoing assessment of both the patient's progress and the treatment interventions. While a full review of the SOAP note format is beyond the scope of this document, Table 6 outlines a summary of its components and providers should refer to additional resources for more information.

Table 6.

SOAP Note Format	
S	**Subjective –** Patient statements that capture the theme of the session. Brief statements as quoted by the patient may be used, as well as paraphrased summaries.
O	**Objective –** Observable data or information supporting the subjective statement. This may include the physical appearance of the patient (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, well-nourished), vital signs, results of completed lab/diagnostics tests, and medications the patient is currently taking or being prescribed.
A	**Assessment –** The counselor's or clinician's assessment of the situation, the session, and the patient's condition, prognosis, response to intervention, and progress in achieving treatment

SOAP Note Format	
	plan goals/objectives. This may also include the diagnosis with a list of symptoms and information around a differential diagnosis.
P	**Plan –** The treatment plan, based on the assessment and clinical information acquired.

The GIRP, SIRP, and BIRP progress note formats are also used to record similar clinical information in a structured format. The information included in these progress note formats includes patient goals/situation/behavior, staff interventions used during the session, patient response to the session, and the plan for future sessions or progress made toward the treatment plan. Similar to the SOAP note format, GIRP, SIRP, and BIRP notes provide a standardized structure for documentation that better ensures a comprehensive and consistent quality of care. Tables 7, 8, and 9 summarize the key components of GIRP, SIRP, and BIRP progress notes, although a full review of these standardized formats is beyond the scope of this document. Providers should refer to additional resources for more detailed information.

Table 7.

GIRP Note Format	
G	**Goal –** Patient's current focus and/or short-term goal, based on the assessment and treatment plan.
I	**Intervention –** Provider's methods used to address the patient's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The patient's response to intervention and progress made toward individual plan goals and objectives.
P	**Plan** – The treatment plan moving forward, based on the clinical information acquired and the assessment.

Table 8.

SIRP Note Format	
S	**Situation –** Patient's presenting situation at the beginning of intervention. May include counselor/clinician observations, patient's subjective report and the intervention setting.
I	**Intervention –** Provider's methods used to address the patient's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The patient's response to intervention and progress made toward individual plan goals and objectives.
P	**Progress** – The treatment plan progress made toward treatment goals and objectives, as well as the plan for future interventions as determined by the clinical picture.

Table 9.

BIRP Note Format	
B	**Behavior –** Patient statements that capture the theme of the session and provider observations of the patient. Brief statements as quoted by the patient may be used, as well as paraphrased summaries that closely adhere to patient statements. Provider observations may include the physical appearance of the patient (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, well-nourished, etc.), vital signs, results of completed lab/diagnostics tests, and medications the patient is currently taking or being prescribed.

BIRP Note Format	
I	**Intervention –** Provider's methods used to address the patient's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The patient's response to intervention and progress made toward individual plan goals and objectives.
P	**Plan** – The treatment plan moving forward, based on the clinical information acquired and the assessment.

For patients with multiple health problems, the problems can be numerically prioritized according to severity and treatment need in the plan section for the respective progress note format.

Medical Necessity Criteria

SAPC and its SUD providers need to have a shared definition and understanding of medical necessity that involves diagnosis, impairment, and intervention.

Medical necessity will be consistently applied to ensure equitable access to services, must be established to demonstrate and maintain DMC eligibility, and must also be established for provided services (e.g., residential treatment, Recovery Bridge Housing, etc). Medical necessity can only be determined after a full ASAM assessment; brief triage assessments do not include sufficient information to determine medical necessity.

Medical necessity must be verified by a Licensed Practitioner of the Health Arts (LPHA) via a face-to-face or telehealth review with the individual conducting the assessment (e.g., SUD counselor). While this face-to-face or telehealth review may include the patient, it does not need to, and the face-to-face or telehealth review must at minimum involve the LPHA verifying and signing off on medical necessity and the SUD counselor or individual conducting the assessment.

Medical Necessity Criteria

- Patient must have at least one diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; or for youth under age 21, be assessed to either meet DSM criteria or be at-risk for developing a SUD.

To meet medical necessity criteria, patients must:

- Have at least one diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; or for youth under age 21, be assessed to either meet DSM criteria or be at-risk for developing a SUD.
- Meet the ASAM criteria definition of medical necessity for services, including the ASAM adolescent treatment criteria, when applicable.

- Patient must meet the ASAM treatment criteria for services, including the ASAM adolescent treatment criteria, when applicable. Medical necessity encompasses all six dimensions so that a more holistic concept would be clinical necessity, necessity of care, or clinical appropriateness. Medical necessity pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It must not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality).

Timeliness of Medical Necessity Determination
The LPHA must determine medical necessity within fifteen (15) calendar days of the treatment admission date, and must document the basis for the diagnosis and medical necessity within the individual patient records.

Timeliness of medical necessity determination

The LPHA must determine medical necessity within fifteen (15) calendar days of the treatment admission date, and must document the basis for the diagnosis and medical necessity within the individual's patient record.

Clinical Practice Guidelines

SAPC recognizes that clinical care needs to be an individualized process that balances patient needs, established clinical standards, and available resources. Each clinical case is unique and there are many variables that impact care. However, care guidelines can be helpful to outline generally accepted clinical standards.

The guidelines outlined below are not intended to be a comprehensive overview of all aspects of clinically appropriate substance use care. Providers are expected to reference more detailed clinical guidelines provided through SAMHSA and other respected resources for additional information.

Assessment

There are various types of assessments, including initial DMC eligibility verification, and assessments focusing on medical necessity and clinical care, including level of care determinations. Assessments and its corresponding documentation serve as the foundation of high quality care. In the treatment of persons with SUDs, assessments are an ongoing process and are essential in order to identify patient needs and help the provider focus their services to best meet those needs. They are also an important aspect of patient engagement and treatment planning, and are generally performed in the initial phases of treatment, though not necessarily during the initial visit.

In certain situations, brief and focused assessments may be more appropriate than more extensive assessments. However, the comprehensive treatment of addictions requires a comprehensive assessment to be conducted in the initial phases of treatment. An important competency of counselors/clinicians is to discern when a brief assessment versus a comprehensive assessment is needed. Additionally, collaborative and coordinated care is a key characteristic of quality care and is based on the ability to perform appropriately comprehensive assessments in order to determine the most suitable referral or linkage.

Staff and professionals who possess the appropriate training perform assessments within their scope of practice. Comprehensive clinical assessments are performed by appropriately trained Licensed Practitioners of the Healing Arts (LPHAs) and SUD counselors.

Clinical assessments are based on the ASAM criteria, which includes multidimensional assessments comprised of six dimensions:

1) Acute intoxication and/or withdrawal potential
2) Biomedical conditions and complications
3) Emotional, behavioral, or cognitive conditions and complications
4) Readiness to change
5) Relapse, continued use, or continued problem potential
6) Recovery/living environment

Clinical assessments are based on the ASAM criteria, which includes multidimensional assessments comprised of six (6) dimensions:
1) Acute intoxication and/or withdrawal potential.
2) Biomedical conditions and complications.
3) Emotional, behavioral, or cognitive conditions and complications.
4) Readiness to change.
5) Relapse, continued use, or continued problem potential.
6) Recovery/living environment.

The multidimensional ASAM assessment provides a common language to describe holistic, biopsychosocial assessment and treatment across addiction, physical health, and mental health services. At a minimum, comprehensive assessments include the following elements:

- History of the present episode
- Substance use and addictive behavior history
- Developmental history (as appropriate)
- Family history
- Medical history
- Psychiatric history
- Social history
- Spiritual history
- Physical and mental status examinations, as needed
- Comprehensive assessment of the diagnose(s) and pertinent details of the case
- Survey of assets, vulnerabilities, and supports
- Treatment recommendations

Assessments based on the ASAM criteria ensure that necessary clinical information is obtained in order to make appropriate level of care determinations. Assessments need to be appropriately documented (see Documentation section above), reviewed, and updated on a regular basis, including at every care transition, in order to promote engagement and meet the patient's needs and preferences. If during the course of assessments the patient and provider(s) determine that adequate progress toward treatment goals has been made, plans to build upon these achievements need to be made, which may include transitions to other services and recovery-focused strategies. Similarly, reassessments of the diagnosis, treatment modalities/intensity/goals need to be performed if progress toward agreed upon goals is not being made within a reasonable time.

Patients who no longer meet medical necessity criteria for SUD treatment services, or prematurely exit the SUD system of care, should receive recovery monitoring services for a minimum of 6 months by the last treatment provider of care, who will reengage the individual in treatment if needed.

Drug Testing

While there is not a widely agreed upon standard for drug testing in SUD treatment, it is often a useful tool to monitor engagement and provide an objective measure of treatment efficacy and progress to inform treatment decisions. The frequency of drug testing should be based on the patient's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued drug use has been identified to be more common. Additionally, drug testing is best when administered randomly as opposed to being scheduled, and the method of drug testing (e.g., urine, saliva) would ideally vary as well.

Drug testing should be viewed and used as a therapeutic tool. A punitive approach to drug testing generally does not facilitate a productive relationship with patients and should be avoided. Consequences to drug testing should also be communicated in a therapeutic manner. Decisions about appropriate responses to positive drug tests and relapses should take into account the chronic nature of addiction, recognize that relapse is a manifestation of the condition for which people are seeking SUD treatment, and recognize instances in which medications or other factors may lead to false or appropriately positive drug test results.

SAPC SUD providers are at a minimum expected to implement the two evidence-based psychosocial interventions of Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT).

Psychosocial Interventions

Psychosocial interventions in the treatment of addictions are vital to engaging patients and promoting behavior change, and need to play an integral role in every treatment encounter. Research has shown that the longer a patient is engaged in addiction treatment, the better his or her long-term prognosis. Thus, the quality of the therapeutic alliance between patient and provider and the degree to which hope for recovery is conveyed are essential contributors to positive treatment outcomes.

Research and innovations have yielded significant progress in the development, standardization, and empirical evaluation of psychosocial treatments for SUDs. This has resulted in a wide range of effective programs for SUDs that differ in both theoretical orientation and treatment technique. While a number of approaches and techniques are effective depending on the clinical situation, certain treatment approaches have a stronger evidence base and therefore need to serve as the foundation of a high quality system of SUD care.

In Los Angeles County, although other psychosocial approaches may be used, SUD providers are at a minimum expected to implement the two evidence-based psychosocial interventions of Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT). Below are descriptions of a selection of these evidence-based psychosocial interventions:

- **Motivational Interviewing (MI)**
    - A patient-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment by paying particular attention to the language of change. This approach frequently includes other problem solving or solution-

focused strategies that build on patients' past successes. According to the Motivational Interviewing Network of Trainers, MI "is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

- **Cognitive-Behavioral Therapy (CBT)**
  - According to the National Institute of Drug Abuse's *Principles of Drug Addiction Treatment: A Research-Based Guide*, "Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur with it. A central element of CBT is anticipating likely problems and enhancing patients' self-control by helping them develop effective coping strategies. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use, and developing strategies for coping with cravings and avoiding those high-risk situations." The Matrix Model is an example of an integrated therapeutic approach that incorporates CBT techniques and has been empirically shown to be effective for the treatment of stimulant use.

- **Relapse Prevention**
  - According to SAMHSA's *National Registry of Evidence-Based Programs and Practices*, relapse prevention is "a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide patients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a patient's overall coping capacity."

- **Trauma-Informed Treatment**
  - According to SAMHSA's concept of a trauma-informed approach, "a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in patients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization." Seeking Safety is an example of an evidence-based trauma-informed practice.

- **Psychoeducation**
  - Psychoeducational interventions educate patients about substance abuse and related behaviors and consequences. The information provided may be broad, but are intended to lead to specific objectives. Psychoeducation about substance abuse is designed to have a direct application to patients' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist patients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

Elements of these psychosocial interventions may be used in any type of service setting and need to be performed by trained providers within their scope of practice. Fidelity to these evidence-based models is critical. Of note, the descriptions of the evidence-based psychosocial interventions above are simply summaries and providers are encouraged to refer to other available resources and manuals for more detailed guidance as to the effective clinical application of these approaches.
Implementation of these EBPs will be a contract requirement and monitored through the contract compliance monitoring process. Corrective action ranging from technical assistance to disallowance will occur depending on the nature of the deficiency, frequency and/or severity of the findings.

According to research, a combination of medications and behavioral therapies is more successful than either intervention alone. Subsequently, medication-assisted treatments (MAT) need to be part of a comprehensive, whole-person approach to the treatment of substance use disorders.

Medication-Assisted Treatments

Research has shown that for the treatment of addiction, a combination of medications and behavioral therapies is more successful than either intervention alone. Subsequently, medication-assisted treatments (MAT) need to be part of a comprehensive, whole-person approach to the treatment of SUDs that includes psychosocial interventions such as counseling, behavioral therapies, case management, and care coordination. The passive or active discouragement of the use of addiction medications that have been approved by the U.S. Food and Drug Administration (FDA) is contrary to the science of effective SUD treatment.

Medication-assisted treatment includes obtaining informed consent, ordering, prescribing, administering, and monitoring of all medications for SUDs. Given the biopsychosocial nature of addiction, all available clinically indicated psychosocial and pharmacological therapies need to be discussed and offered as a concurrent treatment option for appropriate individuals with an alcohol and/or opioid related SUD condition at all levels of care. When MAT is part of the treatment plan, licensed prescribers operating within their scope of practice should assist the patient to collaborate in clinical decision-making, assuring that the patient is aware of all appropriate therapeutic alternatives. Informed consent for all pharmacotherapies must be obtained, including discussion about the advantages and disadvantages of MAT, taking into consideration the benefits, side effects, alternatives, cost, availability, and potential for diversion, among other factors.

Patients receiving MAT must receive a minimum of 50 minutes of counseling sessions with a therapist or counselor, not to exceed 200 minutes per calendar month, although additional services may be provided based on medical necessity.

All prescribed MAT should be consistent with generally accepted standards of medical practice and best practice guidelines for the condition being treated. There are currently several FDA-approved medications for the treatment of various types of addiction in adults:

- Opioid Use Disorder
    - Methadone
    - Buprenorphine
    - Naltrexone (oral and long-acting injectable formulation)
        - In addition to the above medications for opioid use disorder treatment, Naloxone is an FDA-approved medication used to prevent opioid overdose deaths.
- Alcohol Use Disorder

  - Naltrexone (oral and long-acting injectable formulation)
  - Disulfiram
  - Acamprosate
- Tobacco Use Disorder
  - Varenicline
  - Bupropion
  - Nicotine replacement therapy

With the exception of methadone and buprenorphine, which can be prescribed in youth age 16 and above if specific criteria are met and if they are under the treatment of a licensed prescriber, MAT is currently only FDA-approved for those over the age of 18. Current and emerging knowledge is that the routine use of MAT for adolescents is premature and requires further study. Other pharmacotherapies are used off-label for the treatment of addiction in adults and adolescents, but should be used cautiously and only on a case-by-case basis when deemed clinically appropriate by a licensed prescriber. The use and dosages of MAT should also be carefully considered in the treatment of elderly and adolescent populations, who oftentimes require unique treatment approaches given variable body composition and metabolism.

Details regarding the availability, pharmacology, and appropriate prescribing of FDA-approved medications for addiction are beyond the scope of this document. However, providers are encouraged to reference published prescribing guidelines and other available resources for additional information regarding medication-assisted treatments. The prescribing of MAT must be in compliance with all federal, state, and local laws and regulations.

Physician Consultation

A physician consultation is a correspondence in which a Referring Physician is seeking advice, opinion, or recommendation from another, usually a specialist with expertise in a specific area of medicine. Based on the information provided by the Referring Physician, the Consultant Physician provides his/her recommendations regarding the specific question asked. In conjunction with the consultant's expert opinion, the Referring Physician utilizes his/her own professional judgment and other considerations (e.g., patient preferences, family concerns, other comorbid health conditions and psychosocial factors) to provide comprehensive patient treatment.

Given the shortage of medically trained addiction specialists in the SUD workforce, the Physician Consultation Service is designed to help facilitate the exchange and dissemination of addiction expertise between physician providers and within the SAPC adult and youth systems of care.

Physician Consultation Services are provided by the University of California, San Francisco (UCSF) Substance Use Warmline to support DMC physicians within the DMC provider network. Physician Consultation requests are intended for physicians only and should not be initiated by non-physicians or patients.

Physician Consultation Services are initiated by calling the UCSF Substance Use Warmline at (855) 300-3595 (more info: http://nccc.ucsf.edu/clinical-resources/substance-use-resources/). These services are available Monday through Friday (excluding holidays) between 7 a.m. and 3 p.m. PST. Voicemail is

available 24-hours per day. Every effort will be made to respond to consultation requests in a timely manner.

The content of the consultative advice offered through Physician Consultation Services is limited to addiction expertise, and these consultations may involve, but are not limited to, management of complex cases, and questions involving medication-assisted treatments (MAT).

Referring Physicians who are based at provider sites and seeking consultation are responsible for initiating the consultation by calling the UCSF Substance Use Warmline. All consultation requests must include a clear explanation as to the reason for the consultation, and include any relevant history and clinical details that help to inform and provide context for the concern/question.

Consultation requests that are non-clinical in nature, administrative, or more appropriate for SAPC staff should be directed to SAPC. For example, if a physician has a question regarding DMC eligibility, service availability, or questions regarding policies/procedures related to substance abuse treatment, these questions should be directed to SAPC. The UCSF Substance Use Warmline provides general addiction expertise and will not be able to answer non-clinical or administrative questions specific to Los Angeles County.

The Consultant Specialist will utilize the information provided by the Referring Physician to provide recommendations focused on the question/concern of the consultation request. In some complex cases, at the discretion of the Consultant Specialist, the question asked by the Referring Physician may be put forth to other addiction specialists to elicit different clinical opinions and alternative treatment options.

For the protection of patients and involved providers, Physician Consultation Services are strictly limited to routine consultation requests. Emergent and urgent consultation needs should be directed to more appropriate resources (e.g., emergency department, psychiatric emergency services). If the Consultant Specialist determines that a consultation request is emergent or urgent, or that the consultation request is otherwise inappropriate (e.g., patient's condition not consistent with services provided by the consult service), the Referring Physician will be notified of this determination and will be provided an explanation for this decision.

Physician Consultation Services are provided as a free service for its provider network. The time DMC physicians spend seeking physician consultation is not a billable service

Documentation expectations for services provided as a result of Physician Consultation Services are the same as documentation requirements in other patient care scenarios. If the Referring Physician utilizes the Physician Consultation Service, the Referring Physician is also responsible for including thorough documentation of the patient encounter and the role of the Physician Consultation Service in informing that encounter. All documentation should use language that is clear and comprehensible to non-physician Licensed Practitioners of the Healing Arts[i] (LPHA) and SUD counselors.

All local, state, and federal confidentiality requirements involving HIPAA and 42 CFR Part 2 must be followed during the Physician Consultation process.

Culturally Appropriate Services

Culturally competent care is critical in providing high quality SUD services. Research indicates that lack of cultural competency in the design and delivery of services can result in poor outcomes in areas such as access, engagement, receptivity to treatment, help-seeking behaviors, treatment goals, and family response.

Providing developmentally, culturally, and linguistically appropriate services is critical to quality care. Lack of cultural competency in the design and delivery of services can result in poor outcomes.

Core practices that address cultural competency include:
- Attitudes, beliefs, values, and skills at the provider level.
- Policies and procedures that clearly state and outline the requirements for the quality and consistency of care.
- Readiness and availability of administrative structures and procedures to support such commitments.

Providers are required to provide services that are developmentally, culturally, and linguistically appropriate, and must ensure that their policies, procedures, and practices are consistent with this requirement. Providers must also ensure that these principles are embedded in the organizational structure of their agency, as well as being upheld in day-to-day operations.

SAPC will promote cultural competency by coordinating trainings designed to educate providers and administrators about various aspects of cultural sensitivity, with the goal of better engaging patients of diverse backgrounds and needs.

Special Populations

Co-Occurring Disorder Population

For the purposes of this document, co-occurring disorders (COD) are defined as when an individual has a combination of any SUD or any mental health condition, though individuals with COD can have physical health conditions as well. The COD must meet the diagnostic criteria independently from the other condition and cannot simply be a cluster of symptoms resulting from a single disorder. The significant co-morbidity of SUDs and mental illness (typically reported as 40% - 80% depending on study characteristics and population) and the growing body of research associating poorer outcomes with a lack of targeted treatment efforts have highlighted the importance of addressing the unique needs of this population.

Integrated treatment coordinates substance use and mental health interventions to treat the whole person more effectively. As such, integrated care broadly refers to the process of ensuring that treatment interventions for COD are combined within a primary treatment relationship or service setting. Research has generally supported that the ideal approach toward treatment for CODs is to address all conditions simultaneously, as opposed to addressing the SUD and mental health condition separately and in a silo of separate treatment approaches. When providers have staff who possess the skills and training to adequately address the needs of the COD population within their scope of practice, integrated care is best provided in-house. However, if providers are unable to provide necessary services to this population, patients with CODs should receive appropriate referrals to providers who are able to deliver these necessary services.

As opposed to addressing health conditions separately and in silos, the ideal approach to treating co-occurring disorders is to address all conditions simultaneously.

According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "Substance Abuse Treatment for Persons with Co-Occurring Disorders," consensus panel members recommend the following guiding principles in the treatment of patients with CODs:

- **Employ a recovery approach –** The recovery perspective essentially acknowledges that recovery is a long-term process of internal change that requires continuity of care over time, and recognizes that these internal changes proceed through various stages, and that treatment approaches need to be specific to the goals and challenges of each stage of the COD recovery process.
- **Adopt a multi-problem viewpoint –** Treatment comprehensively addresses the immediate and long-term needs of the multidimensional problems typically presented by patients with COD. (e.g., housing, work, health care, a supportive network).
- **Develop a phased approach to treatment –** Treatment phases generally include engagement, stabilization, treatment, and continuing care, which are consistent with, and parallel to, the various stages of recovery. Treatment through these phases allows providers to develop and use effective, stage-appropriate treatment interventions.
- **Address specific real-life problems early in treatment –** Given that CODs often arise in the context of social and personal problems, addressing such problems is often an important first step toward achieving patient engagement in continuing treatment.
- **Plan for the patient's cognitive and functional impairments –** Patients with COD often display cognitive and functional impairments that affect their ability to comprehend information or complete tasks. As a result, services need to be tailored to and compatible with the need and functional level of COD patients.
- **Use support systems to maintain and extend treatment effectiveness –** Given that many COD patients have strained support systems, and the central importance of supportive people and environments in the recovery process, a vital element of effective treatment of the COD population is ensuring that patients are aware of available support systems and motivated to use them effectively.

Comprehensive screening and assessments that are multidimensional in nature, combined with accurate diagnostic impressions, form the foundation of high quality integrated services. These elements are discussed in greater detail elsewhere in this document and require a strong therapeutic alliance between counselor/clinician and patient to allow for open and accurate communication. An important component of being able to develop a therapeutic alliance with the COD patient is the counselor or clinician's own comfort level in working with the patient. Some SUD counselors/clinicians may find some patients with significant mental health conditions threatening or unsettling, and likewise, some mental health clinicians may feel uncomfortable or intimidated by patients with SUDs. As a result, it is critical for the counselor/clinician to recognize these feelings so that they can develop strategies to avoid

allowing them to interfere with the treatment of the COD patient. Oftentimes, these reactions can eventually be overcome with further experience, training, supervision and consultation with a supervisor or peer, and mentoring.

While SUD counselors and staff are not expected to diagnose mental health disorders, it is important that they familiarize themselves with the terminology, criteria, and how to identify if there may be mental health concerns that may benefit from referral to other health providers. In order to meet the needs of this population, SUD counselors and clinicians need to receive training designed to help them better understand the signs and symptoms of mental disorders and how and when to access medical or mental health support.

Appropriate staffing is a key element of effectively addressing the needs of the COD population. An organizational commitment to professional development, skills acquisition, values clarification, and competency attainment is necessary to implement integrated care programs successfully and to maintain a motivated and effective staff. Ideally, enhanced staffing for COD patients at SUD treatment sites would include mental health professionals, and vice versa at mental health treatment sites. Alternatively, establishing appropriate referral relationships and referral processes and protocols can also help to ensure comprehensive and necessary care for individuals with COD.

Psychosocial interventions that have been demonstrated to be effective for the COD population include motivational enhancement, contingency management, relapse prevention, and cognitive–behavioral techniques. These strategies need to be tailored to the patient's unique stage of recovery and can be helpful even for patients whose mental disorder is severe. For patients with functional and cognitive deficits in areas such as understanding instructions, repetition and skill-building strategies can aid progress. Finally, 12-Step and other dual recovery mutual self-help groups may be valuable as a means of supporting individuals with COD, and counselors and clinicians often play an important role in facilitating participation in such groups. In general, the ability to balance the need for empathy and support, and the need to be firm, is essential in maintaining the therapeutic alliance with a patient who has a COD. A straightforward and factual presentation of conflicting material or of problematic behavior in an inquisitive and caring manner can be both "confrontational" and caring at the same time.

The use of appropriate psychotropic medications and medication-assisted treatments for addiction are an essential component of the treatment of individuals with a COD. Oftentimes the appropriate use of medications can help COD patients stabilize and control their symptoms so that they can better focus on their recovery for either their substance use or mental health conditions. Research had clearly demonstrated that medications used in conjunction with psychosocial interventions for both SUDs and mental illness is preferable and leads to better outcomes than either intervention alone. An important component of the treatment of COD patients is thus ensuring a recovery environment that is supportive of the various and individualized paths to recovery that many patients with CODs take. This includes ensuring that staff is receptive to the use of medications for both substance use and mental health conditions when determined to be necessary and appropriate by counselors and clinicians practicing within their scope of practice.

In summary, the treatment of COD patients requires a comprehensive and flexible treatment approach, in addition to coordination with other systems of care.

Perinatal (Pregnant and Postpartum) Patients

Perinatal substance use can result in significant maternal, fetal, and neonatal morbidity. In this instance, the perinatal period is described as the period during pregnancy and sixty (60) calendar days following birth. Research indicates that targeted interventions to pregnant women with SUDs increases the incidence of prenatal visits, improves birth outcomes, and lowers overall health care costs for both mother and baby. The unique needs of pregnant and postpartum women must be considered in the provision of services for this special population.

There is widespread agreement that treatment for pregnant and postpartum women is more effective when the services provided are wide-ranging. Care for this population needs to be interdisciplinary, comprehensive, evidence-based, and coordinated in order to best address issues related to prenatal, perinatal, and postpartum mental and physical health concerns. Psychosocial and practical issues need to be considered as well, as transportation and childcare are common barriers to treatment in this population.

Motivational therapies are critical to the engagement and recovery process. While there is overlap between treatment approaches for the general population and pregnant/postpartum patients, ideal therapies for this special population incorporate treatment elements that are unique to this group, such as promoting bonding with the expected child, reproductive health planning, and targeted case management and care coordination to address the material and physical/mental health needs that accompany pregnancy. The initial assessment, treatment plan, and reassessments of progress need to take into account the varied needs related to the health and well-being of both woman and fetus/infant.

Ideal therapies for pregnant/postpartum patients incorporate treatment elements that are unique to this group, such as promoting bonding with the expected child or infant, reproductive health planning, and targeted case management and care coordination to address the material and physical/mental health needs that accompany pregnancy.

Federal priority guidelines for SUD treatment admission give preference to pregnant and/or female substance and injection drug users. However, a specific level of care is not prescribed and thus the appropriate setting and level of care for this population needs to be consistent with the ASAM criteria, with consideration of the ability to accommodate the physical stresses of pregnancy (e.g., climbing stairs, performing chores, bed rest when medically required, etc.) and the need for safety and support during this period. Level of care determinations need to be based on individualized and multidimensional ASAM assessments, and may lead to placement recommendations in the residential or outpatient setting, depending on clinical need.

Staff working in settings that provide services for pregnant and postpartum patients need to be trained in proper procedures for accessing medical services related to prenatal care, labor and delivery, and therapeutic responses to the varied positive and negative outcomes of pregnancy. Services need to be provided in a non-judgmental, supportive, and open environment.

The use of MAT during pregnancy needs to include careful and individualized consideration of the potential impact of both treatment and lack of treatment on mother and baby. Though there is some risk in using medications during pregnancy, there is also known risk in the inadequate treatment of addiction during pregnancy, and this needs to be considered and discussed with patients. For pregnant women with opioid use disorders, MAT such as methadone and buprenorphine are the standard of care. In these instances, informed consent needs to be obtained, including discussions regarding Neonatal Abstinence Syndrome and what to expect at delivery. Opioid detoxification should also be reserved for selected women because of the high risk and potential consequences of relapse on both mother and

baby. The risks and benefits of breastfeeding while patients are receiving medication-assisted treatments need to be weighed on an individual basis. Methadone and buprenorphine maintenance therapy are not contraindications to breastfeeding.

Given that women may be at increased risk of resuming substance use following delivery, treatment should not end with delivery. Post-delivery treatment services include, but are not limited to: support for parenting a newborn, education about breast feeding, integration with other children and family members, case management for practical needs such as legal assistance, equipment and clothing, coordination of physical and mental health services as needed, coping with the physical and psychosocial changes of the postpartum period, reproductive health planning, and encouragement of the continued pursuit of recovery goals.

Adolescent Patients

For youth, casual substance use can quickly escalate to highly problematic abuse, which highlights the importance of early invention in this population.

Adolescence represents an opportunity to influence risk factors that are still dynamic and not yet entrenched in their influence on development and addiction. Adolescent SUD treatment needs to be approached differently than adults because of differences in their stages of psychological, emotional, cognitive, physical, social, and moral development. Examples of these developmental issues include their newly formed independent living skills, the powerful influence of interactions between adolescent and family/peers, and the fact that a certain degree of limit-testing is a normal feature of adolescence.

Generally, optimal treatment of the adolescent population requires greater amounts of external assistance and support compared to adults, and more intensive treatment and/or higher levels of care for a given degree of severity or functional impairment, when compared with adults.

Although most adolescents do not develop classic physical dependence, physical deterioration, or well-defined withdrawal symptoms as is common for adults who have longer durations of substance use, adolescents may be more susceptible to the functional impact of SUDs. For youth, casual substance use can quickly escalate to highly problematic abuse. Subsequently, adolescents often exhibit higher rates of co-occurring disorders, such as anxiety and depression, because of the negative impact that substance use has on normal adolescent social and psychological development.

These unique characteristics of the adolescent population are reflected in both clinical practices as well as in the ASAM criteria, as adolescents tend to require more intensive levels of care than their adult counterparts. As a result, the patient-to-counselor ratio for adolescent cases is ideally less than the ratio for adult cases to accommodate for this increased treatment intensity.

Due to the rapid progression of adolescent substance use, particular attention must be paid to streamlining the treatment admission process so that adolescent SUD needs are identified and addressed as soon as possible. Strategies to engage adolescents, hold their attention, channel their energy, and retain them in treatment are especially critical. Adolescent treatment needs to also address their increased rates of co-occurring disorders, highlighting the need to coordinate care with the mental health system, as clinically indicated.

Treatment planning needs to begin with a comprehensive assessment based on the ASAM criteria. The assessment includes all the dimensions and biopsychosocial components of the complete adult

assessment, the nuances of the adolescent experience, and their unique needs and developmental issues. Strengths and weaknesses need to be identified and adolescents need to be involved in setting their treatment objectives. Comprehensive adolescent assessments include information obtained from family, and when the appropriate releases are obtained, members of the community who are important to the adolescent patient, such as school counselors, peers, and mentors. The support of family members is important for an adolescent's recovery and research has shown improved outcomes for interventions that seek to strengthen family relationships by improving communication and improving family members' ability to support abstinence from drugs.

During treatment of the adolescent population, every effort needs to be made to support the adolescent's larger life needs in order to maximize the likelihood of treatment success, for example by having flexible weekend and evening hours to accommodate continued engagement with school and appropriate social activities. These larger life issues may be related to medical, psychological, and social well-being, as well as housing, school, transportation, legal services, cultural and ethnic factors, and any special physical or behavioral issues. Failing to address such needs simultaneously could sabotage the adolescent's treatment success.

Behavioral therapies, delivered by trained counselors and clinicians practicing within their scope of practice, need to be employed to help adolescent patients strengthen their motivation to change. Effective psychosocial interventions may provide incentives for abstinence, build skills to resist and refuse substances and deal with triggers or craving, replace drug use with constructive and rewarding activities, improve problem-solving skills, and facilitate better interpersonal relationships.

The use of MAT for adolescents is promising, but the current and emerging knowledge is that the routine use of MAT for adolescents is premature and requires further study. With the exception of methadone and buprenorphine, which can be prescribed in youth age 16 and above if specific criteria are met and if they are under the treatment of a licensed prescriber, there are currently no FDA-approved medications for the treatment of addictions in adolescents. As a result, the use of MAT for adolescents should be considered and used cautiously and only on a case-by-case basis when deemed clinically appropriate by a licensed prescriber. While most adolescents do not develop classic physical dependence or well-defined withdrawal symptoms as a result of shorter durations of substance use compared with adults, youth opioid addiction is an exception that at times may require MAT when clinically indicated, particularly for severe withdrawal symptoms.

The ASAM level of care criteria for adolescents are distinct from that of adults, and are tailored to the particular needs of this population. In general, the ASAM criteria tends to place adolescents in more intensive levels of care than their adult counterparts.

Treatment services for adolescents occur in a setting that is clinically appropriate and comfortable for this population. The adolescent treatment environment should be physically separate from that of adult patients. Staff also need to be familiar and appropriately trained to address the developmental nuances of caring for this unique population.

Similar to other groups, treatment of the adolescent population is regarded as a dynamic, longitudinal process that is consistent with the chronic disease model of addiction. As such, effective treatment is expected to continue into adulthood, with a gradual transition to adult SUD services.

Adolescent patients should be referred to a qualified adolescent/youth outpatient treatment agency where they will receive a full assessment and referral to an appropriate LOC as necessary. If the individual initially presents at a SUD treatment provider that does not offer the appropriate provisional LOC, that agency will identify alternate referral options and assist the individual in connecting with the selected agency, or the individual may elect to remain with the initial provider if clinically appropriate. All Medi-Cal eligible beneficiaries will be referred to, and/or served by, a DMC certified agency for DMC reimbursable services.

The treatment needs of young adults will generally be more intensive than the typical adult, but less intensive than the typical adolescent.

Young Adults

In this document, the term "young adult" refers to individuals between the ages of 18 – 25 and represents young people transitioning into adulthood, some of whom may have received services from the adolescent service system and may need continued services and supports from the adult system. Clinically, age range definitions should be viewed flexibly given the variable nature of chronological age and developmental maturity. This population presents unique service challenges because they are often too old for youth services, but may not be ready for adult services. Young adults are simultaneously emerging into independence while still relying on the support of parents and caregivers. The mixture of adolescent and adult characteristics in the young adult population often requires a specialized approach due to issues of confidentiality, financial support, and shared living environments, among others.

In general, the treatment needs of young adults will be more intensive than the typical adult, but less than the typical adolescent. This will require a blending of programs that currently exist for adolescents and adults, and ideally would occur within programs with specific expertise in treating this population. The approach toward caring for young adults needs to include a flexible mixture of treatment techniques depending on prior contacts with the treatment system and the unique needs of each clinical case. For young adults who have previously been served in the youth system of care for their substance use and other health needs, every effort need to be made to coordinate care with their prior providers to determine the best treatment approach. Prior response to interventions should inform and guide future interventions, with the understanding that the approach toward treatment would be dynamic as young adults transition into adulthood.

Multidimensional assessments include determinations of the developmental stage of young adult populations to help inform treatment approaches and whether care modeled after adolescent approaches or adult approaches may be more appropriate. Strengths and weaknesses need to be identified and young adults need to be involved in treatment planning. When the appropriate authorizations are obtained, family should be involved in the information gathering and treatment process, when family involvement is clinically appropriate and determined to be beneficial.

Similar to youth, young adults typically have various life needs beyond their substance use treatment, and every effort need to be made to support these needs to increase the likelihood of positive outcomes. These larger life issues may be related to medical, psychological, and social well-being, as well as housing, school, transportation, legal services, cultural and ethnic factors, and any special physical or behavioral issues.

Behavioral therapies and MAT, delivered by trained counselors and clinicians practicing within their scope of practice, should be employed depending on clinical need. As discussed in the Medication-

Assisted Treatment section of this document, there are various medications used for addictions that have been FDA-approved for individuals over the age of 18 (and some over the age of 16), and need to be a treatment option available to young adults in conjunction with psychosocial interventions and as a component of a multifaceted treatment approach. Effective psychosocial interventions may provide incentives for abstinence, enhance motivation for change and recovery, build skills to resist and refuse substances and deal with triggers or craving, replace drug use with constructive and rewarding activities, improve problem-solving skills, and facilitate better interpersonal relationships.

Ideally, staff working with the young adult population would be familiar with and interested in working with the unique needs of this population. They should have experience in treating both the adolescent and adult populations in order to best blend necessary treatment approaches.

While the ASAM criteria does not specifically explore the specialized considerations of young adults, the ASAM criteria does note that an intermediate stage between adolescence and adulthood may become standard in the future, with accompanying treatment approaches that are individualized to address the unique assets, vulnerabilities, and needs of this group.

Older Adults

Given the chronic nature of substance use disorders and the expanding population of older adults, it is increasingly important to modify treatment approaches to the unique needs of this population. In general, older adults include individuals over the age of 65, but this definition should be individualized based on clinical need. For example, some individuals younger than age 65 may have cognitive deficits, medical conditions, or social situations that necessitate the utilization of treatment approaches that are more typical for individuals of more advanced age.

Health care providers sometimes overlook substance use in the older adult population over the age of 65, mistaking symptoms and indications of substance use for dementia, depression, or other problems common to this population.

Key differences between older and younger populations necessitate different approaches toward treatment. Due to altered metabolism and brain function, and the medical conditions that often accompany advanced age, the quantity and frequency of substance use in older adults may underestimate the functional impact in this population and create diagnostic challenges. In addition to the fact that many older adults are retired, limiting the sensitivity of using work or social impairment as a diagnostic indicator, a smaller amount of alcohol or substances may impact older adults more severely than younger counterparts. Health care providers also sometimes overlook substance use in this population, mistaking symptoms and indications of substance use for dementia, depression, or other problems common to older adults. Social isolation, lack of transportation, and heightened levels of shame and guilt in this group may make accessing services for the older adult population more difficult than other age groups. As a result older adults may be more likely to attempt to hide their substance use and less likely to seek professional help. Older adults are also more likely to be primary caregivers for a spouse who has greater needs than their own, which may limit their willingness to enter into treatment due to their caregiving responsibilities.

Research has demonstrated that age-specific assessment and treatment is associated with improved outcomes when compared with mixed-aged treatment. Assessments need to be age-specific and multidimensional, given the various physical and mental health needs, as well as social needs, of the older adult population. The treatment of older adults needs to be paced to the individual's physical and cognitive capabilities and limitations. The schedule of programs and expectations, and the overall

timeframe for clinical progression and change is typically slower for older adults than other age groups. As such, treatment programs should be realistically designed to accommodate these anticipated differences.

Studies have generally indicated that cognitive-behavioral techniques are effective for older populations, particularly those that address negative emotional states that pose significant risk for relapse (e.g., self-management approaches for overcoming depression, grief, or loneliness). In general, confrontational therapy in this population has been shown to be less effective than in other age groups and should be avoided. Educational treatment approaches should be geared toward the specific needs of older adults (e.g., coping strategies for dealing with loneliness, general problem-solving). Older adults may absorb presented information better if they are given a clear statement of the goal and purpose of the session and an outline of the content to be covered. Repetition of educational information may also be helpful (e.g., simultaneous visual and audio).

Given that social isolation is a common problem in this population, group therapies and skill building around establishing social support networks are often beneficial, in addition to family therapy. According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "Substance Abuse among Older Adults," consensus panel members recommend limiting involvement of family members or close associates to one or two members to avoid overwhelming or confusing older adults. Panel members also suggest that the involvement of grandchildren may lead to obstacles for open communication, as older adults may at times resent their problems being aired in the presence of younger relatives.

Medications used in older populations, including MAT, should be used with caution due to the physiological changes that occur with advanced age. Dosages of medications may need to be lowered, particularly if co-morbid medical conditions are involved. In cases where medications are used for withdrawal management, dosages for older populations should often be one-third to one-half the usual adult dosage. Concerns or questions regarding the safe use of medications in the older adult populations need to be directed toward appropriately trained medical professionals.

Staff working with older adults should ideally have training in aging and geriatric issues. Staff should also have an interest in working with this population and the skills required to provide age-specific services for individuals of more advanced age. The best results are typically achieved when staff is experienced in dealing with the physical, psychological, social, and spiritual issues unique to older adults. Staff who interacts with older patients need to receive regular trainings on empirically demonstrated principles and techniques effective for older populations.

In general, panelists from SAMHSA recommend the following treatment approaches for the older adult population:

- Treat older people in age-specific settings, where feasible, ensuring appropriate pace and content of treatment.
- Create a culture of respect for older patients. Follow treatment approaches that are supportive, non-confrontational, and aim to build self-esteem.
- Take a broad, flexible, holistic approach to treatment that emphasizes age- and gender-specific psychological, social, and health problems. These approaches need to include building social support networks and coping skills dealing with depression, loneliness, and loss.
- Staff working with older adults need to be interested and experienced in working with this population.

Patients Involved with the Criminal Justice System

The criminal justice system includes accused or adjudicated who require various SUD services. Parole and probation status is not a barrier to SUD treatment services provided that the parolees and probationers meet the DMC eligibility verification and medical necessity criteria. For many people in need of alcohol and drug treatment, contact with the criminal justice system is their first opportunity for treatment. Services can be provided through courts, probation or parole agencies, community-based or institutional settings, or in sex offender programs. In each of these situations, the individual is accountable to comply with a criminal justice sanction. Legal incentives to enter SUD treatment at times motivate individuals to pursue recovery, whereas for other offenders, arrest and incarceration are part of a recurring cycle of drug abuse and crime.

Ingrained patterns of maladaptive coping skills, criminal values and beliefs, and a lack of job skills may require a more intensive treatment approach for the criminal justice population, particularly among offenders with a prolonged history of substance abuse and crime. However, strong empirical evidence over the past several decades has consistently shown that the criminal justice population can be effectively treated and that SUD treatment can reduce crime.

Criminal justice patients from cultural minority groups may have unique cultural needs. For example, women offenders are more likely to have been traumatized by physical and sexual abuse and to have concerns about their children, and many offenders have co-occurring substance use and mental health conditions that can complicate treatment.

Staff working with criminal justice populations need to be specifically trained in working with criminogenic risk, need, and responsivity (RNR), as well as SUDs and CODs. Staff also need to be capable of integrating identified treatment goals with the goals of the involved agencies. As a result, it is critical for treatment providers to have a strong working relationship with probation and parole officers, judges, the court, and other legal entities involved in the patient's care.

The first step in providing SUD treatment to people under criminal justice supervision is to identify offenders in need of treatment. Comprehensive assessments incorporate issues relevant to criminal justice involved individuals, such as assessment of criminogenic RNR, anger management, impulse control, values and behaviors, family structure and functioning, criminal lifestyle, and antisocial peer relationships. Assessments also pay particular attention to CODs, developmental and cognitive disorders, and traumatic brain injury.

In general, clinical approaches and the use of MAT need to be consistent with those utilized for individuals who are not involved with the criminal justice system, and a qualified counselor/clinician should determine the appropriate level of placement and interventions rather than court/probation requirements. Treatment interventions need to be based on a multidimensional assessment and individualized needs. However, working with the criminal justice population does have unique requirements that necessitate modified treatment approaches in order to meet their specific needs. Additionally, it is essential to collaborate with correctional staff to ensure that the treatment goals align with correctional and supervision case planning and/or release conditions (particularly involving the prescription of certain MAT).

For example, offenders from cultural minority groups may have unique cultural needs, women offenders are more likely to have been traumatized by physical and sexual abuse and to have concerns about their children, and many offenders have co-occurring substance use and mental health conditions that can complicate treatment. Strategies to engage offender populations are especially critical. Criminal justice

patients often have problems dealing with anger and hostility, and experience the stigma of being criminals, along with accompanying guilt and shame. Other groups with specific needs include older adults, violent offenders, people with disabilities, and sex offenders.

Clinical strategies for working with criminal justice patients may include interventions to address criminal thinking and provide basic problem solving skills. Providers need to be capable of using evidence-based practices designed to address SUDs, mental health, and criminogenic needs. For example, motivational interviewing, cognitive behavioral therapy that focuses on both substance use and antisocial behaviors that lead to criminal recidivism, trauma-informed care, and contingency management therapies.

Due to court mandates, classification policies and procedures, various security issues, and differences in available programming, one of the challenges of working with the criminal justice population is determining when the ASAM criteria can be meaningfully applied. The ideal scenario is for the level of care setting to match the severity of illness and functional impairment, similar to the general population. However, there are instances in working with offenders that necessitate close collaboration with correctional staff to provide services that are clinically appropriate and that also align with correctional and supervision case planning and/or release conditions. When skillfully applied, the ASAM criteria can be used to access the full continuum of care in a clinically appropriate manner for the criminal justice population.

Similar to other groups, treatment of offenders needs to be regarded as a dynamic, longitudinal process that is consistent with the chronic disease model of addiction. As such, effective treatment is expected to continue even after the legal issues for criminal justice patients are resolved.

Services that link patients to secure housing early in treatment tend to produce better outcomes, emphasizing the importance of case management in order to meet the varied needs of homeless patients.

Homeless Population

Homelessness is an issue that impacts many individuals with SUDs as a result of the socioeconomic decline that oftentimes accompanies addictions. Conservative estimates of the prevalence of substance use among homeless individuals are approximately 20 – 35%. Although homeless patients typically require more intense treatment and have greater and more varied needs than housed individuals, homeless patients pose significant challenges to the SUD treatment community because of the various structural, interpersonal, and biopsychosocial barriers they face in accessing care. Some of these obstacles include social isolation, distrust of authorities, lack of mobility and/or transportation, and multiplicity of needs.

There is wide recognition that substance use in the homeless population cannot be treated apart from addressing the needs of the whole person in the context of his or her environment. A continuum of comprehensive services is needed to address the various safety, health, social and material needs of homeless patients. Common examples include assistance with accessing food, clothing, shelter/housing, identification papers, financial assistance and entitlements, legal aid, medical and mental health care, dental care, job training, and employment services. These services may be provided within the SUD program itself or through linkages with existing community resources. Proactive outreach, addressing needs in a non-judgmental and non-threatening environment, and addressing the various identified needs early in treatment may help to better engage this population.

On the whole, research demonstrates that effective programs for homeless patients address their substance use as well as their tangible needs (e.g., housing, employment, food, clothing, finances); are flexible and non-demanding; target the specific needs of subpopulations, such as gender, age, or diagnoses (e.g., COD/TAY/older adult populations); and provide longer-term, continuous interventions. As a result of these diverse needs, effective treatment for homeless patients must involve various disciplines and collaboration across agencies and organizations.

Stable housing is often critical to attaining treatment goals, and is an important component of necessary services. Services that link patients to secure housing early in treatment tend to produce better outcomes, emphasizing the importance of case management in order to meet the varied needs of homeless patients.

Psychosocial interventions and MAT for homeless patients need to mirror the approaches that are successfully used in other populations, with modifications to meet the unique needs of this population. Mobile outreach services are ideal, along with motivational enhancement interventions, in order to encourage continued treatment engagement. As a whole, the homeless population tends to be less responsive to confrontational approaches to treatment. Counselors and clinicians also need to be mindful of the physical and mental health needs of this population, given high rates of co-morbidity for many homeless individuals. Medications should be used when clinically indicated, with prescribing practices that take into consideration the environment in which these medications will be used and stored (for example, care is to be taken to ensure that medications that require refrigeration are not prescribed when the patient has no way to store such medications). Integrated interventions that concurrently address the multitude of medical, psychiatric, substance use, and psychosocial needs of homeless persons tend to produce improved outcomes compared to interventions that are provided sequentially or in parallel with other services.

Successful counselors and clinicians who work with homeless patients tend to have a particular interest and comfort level in working with this challenging and rewarding population. Staff need to be experienced with the various aspects of care involved in working with homeless patients, and need to be familiar with the resources available in the community so that appropriate referrals and linkages can be made in order to best address the varied needs of patients. Ideally, care teams work collaboratively and include interdisciplinary staff comprised of medical, mental health, substance use, and social service providers.

In general, treatment for homeless patients with SUDs is challenging, but successful outcomes can be achieved by prioritizing access to appropriate housing and providing comprehensive, well-integrated, patient-centered services with uniquely qualified staff.

Lesbian, Gay, Bisexual, Transgender, Questioning Population

Lesbian, gay, bisexual, transgender, questioning (LGBTQ) populations tend to experience higher rates of substance use than the general population. The stigma and discrimination of being a member of a marginalized community such as the LGBTQ community causes some individuals to cope with these additional stressors by using substances. Furthermore, research has also shown that once LGBTQ patients do meet the criteria for a diagnosable SUD, they are less likely to seek help. These findings may be due to the various barriers the LGBTQ population faces in seeking treatment, and unique needs LGBTQ patients have that may not be addressed by SUD programs.

Substance use disorder providers need to carefully explore the individual situation and experiences of their patients, particularly in the LGBTQ (lesbian, gay, bisexual, transgender, questioning) population. Failing to do so may result in poor outcomes due to their unique circumstances and needs.

Although there are various protections in place that are intended to shield recovering substance abusers from many forms of discrimination, LGBTQ individuals are oftentimes not afforded the same protections. As a result of homophobia, heterosexism, and/or transphobia, some may find it difficult or uncomfortable to access treatment services and be afraid to speak openly about their sexual orientation or gender identity. Many LGBTQ patients may also internalize the effects of society's negative attitudes, which can result in feelings of sadness, doubt, confusion, and fear. Problems in traditional health care systems may lead to distrust of health care professionals, requiring extra sensitivity from SUD providers.

In many ways, psychosocial and pharmacologic interventions (e.g., MAT) geared toward LGBTQ patients are similar to those for other groups. An integrated biopsychosocial approach takes into account the various individualized needs of the patient, including the societal effects on the patient and his/her substance use. Unless SUD providers carefully explore each patient's individual situation and experiences, they may miss important aspects of the patient's life that may affect recovery (e.g., social scenes that may contribute to substance use, prior experiences being discriminated against, a history of antigay violence and hate crimes such as verbal and physical attacks, etc).

As with any patient, substance use providers need to screen for physical and mental health conditions in LGBTQ persons due to the risk of co-morbid health conditions. As a result of previously discussed challenges confronted by the LGBTQ community, members of this group do have higher rates of certain mental health conditions and are also at greater risk for certain medical conditions. Comprehensive screening and assessments can assist LGBTQ patients in accessing appropriate care for their physical and mental health concerns.

The methods of best practice outlined in the counseling competency model apply to all populations, particularly in working with LGBTQ patients. In this model, a counselor respects the patient's frame of reference; recognize the importance of cooperation and collaboration with the patient; maintain professional objectivity; recognize the need for flexibility and be willing to adjust strategies in accordance with patient characteristics; appreciate the role and power of a counselor as a group facilitator; appreciate the appropriate use of content and process therapeutic interventions; and be non-judgmental and respectfully accepting of the patient's cultural, behavioral, and value differences.

There are also some unique aspects of treating LGBTQ patients that providers need to be aware of. While group therapies should be as inclusive as possible and should encourage each member to discuss relevant treatment issues or concerns, some group members may have negative attitudes toward LGBTQ patients. Staff members need to ensure that LGBTQ patients are treated in a therapeutic manner and group rules should make clear that homophobia is not be tolerated. The LGBTQ patient is solely responsible for deciding whether to discuss issues relating to his/her sexual orientation and/or gender identity in mixed groups and not the other group members. Although providing individual services decreases the likelihood that heterosexism/homophobia/transphobia will become an issue in the group setting, there is also an opportunity for powerful healing experiences in the group setting when LGBTQ patients experience acceptance and support from non- LGBTQ peers.

Family dynamics are also important in working with LGBTQ individuals and SUD providers need to be aware that family therapy may be difficult because of alienation owing to the patient's sexual/gender identity. However, inclusion of family in the treatment process may also result in more positive outcomes. Given common concerns regarding living environments (in terms of recovery and safety), social isolation, employment and finances, and ongoing issues related to sexual orientation or identity, particular attention needs to be paid to discharge planning in the LGBTQ population.

Elements of treatment that promote successful treatment experiences for the LGBTQ patient include cultural sensitivity, an awareness of the impact of cultural victimization, and addressing issues of internalized shame and negative self-acceptance. Cognitive-behavioral therapies challenge internalized negative beliefs and promote emotional regulation, which can be helpful for relapse prevention. Motivational enhancement techniques may also encourage treatment engagement in this population.

Because each patient brings his or her unique history and background into treatment, furthering our understanding of individuals different from ourselves helps to ensure that patients are treated with respect and improve the likelihood of positive outcomes. At times, SUD treatment staff may be uninformed or insensitive to LGBTQ issues, may have preconceived biases toward LGBTQ patients, or may falsely believe that sexual identity/gender identity causes substance abuse or can be changed by therapy. In these cases, providers need to be aware of these beliefs in order to prevent them from becoming barriers to effective treatment of the LGBTQ patient. A substance abuse treatment program's commitment to promote sensitive care for LGBTQ patients can be included in its mission statement and administrative policies and procedures. Providing staff training and education are oftentimes valuable and include sexual orientation sensitivity training to promote better understanding of LGBTQ issues, LGBTQ -specific training, and educational programs to ensure that quality care is provided. Providers who understand and are sensitive to the issues surrounding LGBTQ issues such as culture, homophobia, heterosexism, and sexual and gender identity can help LGBTQ patients feel comfortable and safe while they start their recovery journey.

Veterans

According to U.S. Census estimates, there are over 330,000 veterans who live in Los Angeles County. Although veterans share commonalities, their experiences are as varied and unique as their needs. Some veterans may have experienced combat in one or more wars, while others may have served in non-combat roles. Likewise, some veterans may have experienced injury, including traumatic brain injuries (TBI), loss of limb, or other physical injury, while others may have emotional scars. In particular, gender may also influence veteran experiences, as reports of women veterans who have experienced

sexual harassment and/or physical and sexual trauma are becoming more common. As a result of the cumulative effects of these events and experiences, veterans and family members may develop SUDs and present to treatment with a unique set of needs and circumstances that must be addressed. Under certain circumstances, veterans may be ineligible for Veteran's Administration (VA) benefits due to a dishonorable discharge or discharge "under other than honorable conditions," among other circumstances. Additionally, some veterans and family members may attempt to secure services from SUD treatment programs due to the long wait times at the VA. Regardless of the situation, SUD treatment providers should work to ensure that the services provided address the varied and unique needs of individuals.

While substances of abuse vary, veterans may abuse sedating substances such as prescription drugs in efforts to address untreated/under-treated anxiety or other mental health conditions. Additionally, co-occurring physical health conditions and injury may increase rates of prescription drug and opioid abuse, including the use of heroin, and thus certain veterans may be at higher risk for fatal overdoses and may be appropriate candidates for MAT.

Given the higher likelihood of trauma, physical and behavioral health complications of the veteran population, SUD providers are encouraged to perform thorough assessments that encompass the full range of complications that may be present. For example, assessments may include questions concerning trauma, combat or war experiences, or injuries that may impact the patient's participation in SUD treatment. If the patient reports (or it is determined that) injuries exist that may impact treatment, the SUD treatment provider is encouraged to work with other providers (e.g., medical, mental health) to coordinate care, which is often particularly critical in this population.

Veterans may also have different reasons for their substance use, such as untreated/under-treated physical injury or mental health issue. Stigma is often an additional complicating issues. Although stigma exists around substance use, within the military stigma often also exists for seeking help for any health condition. Anger or personality disorders may also be present, further making treatment engagement difficult. In these instances, effectively engaging veterans and utilizing evidence-based techniques, such as motivational interviewing, will be critical to treatment success.

In summary, treatment providers may need additional training to fully understand the nuances of the veteran population and how their experiences impact their behaviors in order to adequately treat veterans and their families.

Levels of Care Guidelines

Addiction treatment is delivered across a continuum of services that reflect illness severity and the intensity of services required. One of the key goals of SAPC is to facilitate SUD service delivery that is the right service, at the right time, for the right duration, in the right setting. While the levels of care are presented as discrete hierarchies, they need to be viewed as points along a continuum of treatment services, each of which may be provided in a variety of settings.

Referral to a specific level of care must be based on a comprehensive and individualized assessment of the patient, with the primary goal of placing the patient at the most appropriate level of care. Initial referrals may be accomplished through a brief screening tool with a more comprehensive assessment

completed at the treatment program to confirm placement. In Los Angeles County, level of care determinations are based off of the ASAM criteria, which helps to organize the assessment and clinical formulation in a manner that provides more structure and consistency in level of care determinations. In general, the preferable and most appropriate level of care is one that is the least intensive while still safely meeting the unique treatment objectives of the patient and treatment team.

Level of care determinations begin with the ASAM multidimensional assessment in order to explore patient risks, needs, strengths, skills, and resources. Dimension-specific risk ratings are generated from the assessment process and are used to help inform providers as to dimensional priorities, which are subsequently used for service planning and placement. When physical or mental health conditions are apparent, the need for immediate stabilization should be prioritized and the highest severity problem should determine the patient's entry point into the treatment continuum, whether it is within the SUD system of care (including Opioid Treatment Programs), or in the physical or mental health systems. Placement within the levels of care is best conceptualized as a flexible continuum, marked by the ASAM's five broad levels of service, each with gradations of service intensities (see Table 10).

Opioid Treatment Programs (OTPs; aka: Narcotic Treatment Programs) are an essential component of the continuum of care for substance use disorders. As is the expectation with other levels of SUD care, ensuring a flow of appropriate referrals between OTPs and other SUD providers, the provision of necessary services such as case management, and appropriate referrals into other health systems (if needed) are all critical to high quality OTP services. As such, the quality and resource management standards and requirements set within the QI and UM program pertain to OTPs as well, in addition to the various State and Federal requirements that also govern the delivery of care in this setting.

Table 10.

ASAM Continuum of Care	
Level of Care	**ASAM Level**
Early Intervention	0.5
Outpatient Services	1
Intensive Outpatient / Partial Hospitalization Services	2
- Intensive Outpatient Services	2.1
- Partial Hospitalization Services (*not applicable to SAPC system of care*)	2.5
Residential / Inpatient Services	3
- Clinically Managed Low-Intensity Residential Services	3.1
- *Clinically Managed Population-Specific High-Intensity Residential Services *Does not pertain to adolescent populations	3.3
- Clinically Managed High-Intensity Residential Services	3.5
- Medically Monitored Intensive Inpatient Services	3.7
Medically Managed Intensive Inpatient Services	4
Opioid Treatment Program (aka: Narcotic Treatment Program)	OTP

The ASAM criteria also outlines a continuum of five levels of withdrawal management (also known as detoxification) for adults (see Table 11). Given that severe withdrawal is less common in adolescents than in adults, the approach to withdrawal management for adolescents is unique. When adolescent physiologic withdrawal is evident and when the clinical scenario does not require emergent care, a more

integrated approach is ideal and every effort should be made to provide withdrawal management services in the setting in which adolescent patients are receiving their SUD care. Withdrawal management for adolescent populations will be approved by SAPC on a case-by-case basis.

Table 11.

ASAM Continuum of Care- Withdrawal Management (ADULT)	
Withdrawal Management- Level of Care	**ASAM Level**
Ambulatory (Outpatient) Withdrawal Management without Extended On-Site Monitoring	1-WM
Ambulatory (Outpatient) Withdrawal Management with Extended On-Site Monitoring	2-WM
Clinically Managed Residential Withdrawal Management	3.2-WM
Medically Monitored Inpatient Withdrawal Management	3.7-WM
Medically Managed Intensive Inpatient Withdrawal Management	4-WM

A detailed description of ASAM level of care guidelines is beyond the scope of this document. Providers are encouraged to refer to The ASAM criteria textbook or other helpful resources for additional information. Similarly, providers should refer to the contractual requirements of each level of care to ensure compliance with all federal, state, and local mandates. Level of care transitions should follow the relevant preauthorization and authorization protocols established in the UM program.

Services provided at the various levels of care should reflect the patient's clinical condition, including consideration for severity level and functional impairment. Interventions may include, but are not limited to: individual counseling, group counseling, family therapy, patient education, psychosocial interventions, medication-assisted treatments, collateral services, care coordination, case management, crisis intervention, treatment planning, recovery support services (recovery monitoring/coaching, educational and vocational support, housing assistance, transportation services, peer and family support, spiritual support, etc.), and discharge services.

As patients transition between levels of service, progress in all six dimensions should be formally assessed at regular intervals, in accordance with the patient's severity level and functional impairment, as clinically indicated. These assessments help to ensure that patients are placed in the appropriate level of care and must be based on medical necessity, which need to be performed by the Medical Director, licensed physician, or LPHAs. Level of care transitions need to be based on clinical need, as opposed to funding source or provider preferences.

Continuity of care and longitudinal follow up are critical for SUD patients. Referrals and linkages to different service and levels of care within the SUD, physical, and mental health systems help to ensure that patient needs are appropriately addressed. High quality care is characterized by the seamless linking of different levels of care, both within the SUD system of care and between other systems of health care. This streamlined system of care can be achieved by care coordination, case management, role induction (preparing individuals for treatment by sharing the rationale of treatment, treatment process, and their role in that process), warm hand-offs, and assertive outreach.

In cases in which the recommended level of care is not available, which can occur due to a variety of reasons (lack of availability, funding limitations, resource constraints, etc.), the treatment plan needs to be revised in order to provide needed services in a different placement. Effectiveness and safety should be first priority in these circumstances, which may require that patients be placed in higher levels of care than the ASAM criteria indicates. In these instances, it is the providers' responsibility to advocate for the patient and justify and explain the rationale for the alternative level of care or intervention, based on the available clinical documentation.

Recovery Bridge Housing

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." SAMHSA has also outlined four major dimensions that support a life in recovery – health, home, purpose, and community.

According to the ASAM criteria, a comprehensive SUD assessment should include the consideration of six dimensions in order to determine appropriate level of care (LOC) placement for patients diagnosed with a SUD. Recovery/Living Environment (Dimension 6) explores an individual's recovery or living situation, and is one of the six dimensions that should be factored into LOC decisions. Importantly, a combination of risk factors in multiple ASAM dimensions contribute to appropriate LOC placement, including residential treatment settings. Homelessness or lack of safe, stable housing does not in and of itself mean that a patient would be appropriate for placement in a residential treatment setting.

Housing and residing in a safe living environment is oftentimes a critical component to the ability to maintain recovery from SUDs. Research shows that SUD treatment outcomes are better for persons experiencing homelessness, particularly chronic homelessness, when they are stably housed. RBH can provide a safe interim living environment for patients undergoing treatment in outpatient (OP), intensive outpatient (IOP), Opioid Treatment Program (OTP), or Outpatient (aka: Ambulatory) Withdrawal Management (OP-WM) settings. RBH also allows for access to case management in a field-based setting, which can help patients transition into permanent housing and maintain their long-term recovery.

Recovery Bridge Housing (RBH) is defined as a type of abstinence-based, peer supported housing that combines a subsidy for recovery residences with concurrent treatment in OP/IOP/OTP/OP-WM settings. RBH is often appropriate for individuals with minimal risk with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions. The services provided in RBH vary, and include peer support, group and house meetings, self-help, and life skills development, among other recovery-oriented services. Treatment services cannot be provided in RBH.

RBH aligns with the spirit of the ASAM criteria in the sense that individuals should be appropriately placed in the least restrictive treatment environment necessary in order to meet their clinical needs. While RBH is not officially an ASAM LOC, it serves as a bridge between the more intensive and restrictive residential treatment setting and OP/IOP/OTP/OP-WM treatment with no housing component attached. With the enhanced utilization controls of the DMC-ODS, there will likely be a greater reliance on RBH as

well as other housing options for individuals in OP/IOP/OTP/OP-WM treatment settings who require recovery-oriented housing while they receive SUD treatment.

Clinical experience and research supports the notion that patients with SUDs need access to safe, stable, and supportive living environments to help them initiate and sustain their recovery and reduce the risk of relapse. As more individuals access SUD treatment through the DMC-ODS, the need to expand housing options to support individuals with their recovery is critical.

A continuum of housing options should be available to accommodate the varied needs and preferences of patients. Some individuals may need short-term housing while they work to get back on their feet, while others need access to permanent supportive housing. Within the community, it is also important for those with SUDs to have access to both abstinence-focused housing in RBH, as well as low barrier housing that is available in the community via the Coordinated Entry System (CES) and does not require abstinence for those individuals who are not yet ready or able to achieve abstinence.

Table 12.

	Recovery Bridge Housing Foundational Principles
1	Agencies managing RBH should not restrict access to this benefit to their own clients. RBH beds should be available to any patient that is eligible for this benefit within the SUD system of care and belong to one of the groups prioritized for this benefit.
2	Prioritization for RBH will be given to the following patients*: - Perinatal patients (pregnant to 60 days postpartum) - Active intravenous Drug Users (injected drugs within the last 30 days) - High utilizer patients (as defined by high utilizer criteria for SAPC high tier care management[1]) - Chronically homeless (according to HUD definition[2]) - Certain non-AB 109 criminal justice patients without alternative criminal justice funding for recovery housing - Transition Age Youth (TAY: "young adults" 18-25) - HIV/AIDS patients - Lesbian, gay, bisexual, transgender and questioning (LGBTQ) populations

[1] **SAPC high tier care management inclusion criteria** – All individuals diagnosed with a SUD who meet any of the following criteria:

a. 3+ ED visits related to SUD within the past 12 months
b. 3+ inpatient admissions within the past 12 months for physical and/or mental health conditions and co-occurring SUD
c. Homelessness with SUD (as defined by HUD homelessness definition)
d. 3+ residential SUD treatment admissions within the past 12 months
e. 5 + incarcerations with SUD in 12 months

[2] HUD definition of **homelessness** includes four categories: 1) **Literally Homeless**: individual or family who lives in a place not meant for human habitation or in an emergency shelter or is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution; 2) **Imminent Risk of Homelessness**: Individual or family who will imminently lose their primary nighttime residence within 14 days and who lacks the resources to obtain other permanent housing; 3) **Homeless Under Other Statutes**: includes unaccompanied youth under 25 or families with children and youth who have experienced persistent instability (see terms and definitions for more information); and 4) **Fleeing/Attempting to Flee Domestic Violence**: An individual or family attempting to flee DV who has no other residence and lacks the resources or support networks to obtain other permanent housing.

HUD definition of **chronic homelessness** is "a person must have a disability and have been living in a place not meant for human habitation, in an emergency shelter, or a safe haven for the last 12 months continuously or on at least four occasions in the last three years *where those occasions cumulatively total at least 12 months"* (United States Department of Housing and Urban Development 2016).

	* Populations other than the prioritized populations will only be authorized for RBH if sufficient capacity is available to accommodate prioritized populations. Note: Undocumented homeless adult patients who meet the prioritization criteria listed above are eligible for placement in RBH.
3	Eligible participants should be medically and psychiatrically stable enough to benefit from RBH.
4	Program participation is self-initiated and patient chooses abstinence-focused housing.
5	Program policies and operations should be consistent with the National Standards for Cultural and Linguistically Appropriate Services (CLAS) and ensure individual rights of privacy, dignity, respect and safety.
6	Programs should emphasize the personal recovery goals of participants and long-term housing stability so as to minimize the likelihood of homelessness.
7	Program design should establish minimal barriers for entry into programs.
8	Program must meet or exceed National Alliance for Recovery Residence (NARR) standards of care. (SAPC is in the process of developing RBH program standards of care that will serve as the minimum standard once established).
9	Holistic services and peer-based supports are available to all program participants.
10	Relapse is not treated as an automatic cause for eviction from housing or termination from the program.
11	Discharge from housing should only occur under two conditions. First when a participant's behavior substantially disrupts or impacts the welfare of the recovery community in which the participant resides, and secondly, if the participant is no longer able to benefit from RBH due to becoming medically or psychiatrically unstable. Participants may apply to reenter the program if they express a renewed commitment to living in an abstinence-focused housing setting.
12	Participants who determine they are no longer interested in living in abstinence-based housing or who are discharged from the program are offered assistance in accessing other housing and service options.
13	Throughout the duration of program participation, programs are required to help patients transition into permanent housing options to ensure a smooth transition once they are ready to leave the program.

The core goal of RBH is to provide a safe living space that is supportive of recovery for patients who are receiving OP/IOP/OTP/OP-WM treatment for their SUD. Certain populations, such as those experiencing homelessness, are particularly at risk for relapse without access to housing and should be prioritized for this benefit. SAPC's Foundational Principles of Recovery Bridge Housing (see Table 12) are based on characteristics of Recovery Housing as defined by the U.S. Department of Housing and Urban Development (HUD), as well as recommendations from the California Department of Health Care Services around best practices.

Assessing Placement in Housing

Before being admitted to treatment, all SUD patients should be assessed at the SUD treatment facility site to which they have been referred on all six ASAM dimensions, including ASAM dimension 6 – Recovery/Living Environment.

For patients who report they are homeless at intake, an assessment using the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) should be conducted as soon as possible after all patients been admitted to SUD treatment to give case managers sufficient time to work with patients to find an appropriate housing placement. The VI-SPDAT assesses and triages homeless individuals based on their health and behavioral health needs to match them with appropriate housing and services, and is a necessary first step in order to access housing options beyond the RBH that will be available within SAPC's network, in particular housing options through the CES.

SUD providers should discuss housing preferences with patients, and combined with their professional judgment, determine if housing in RBH – which requires abstinence from drugs/alcohol and continued SUD treatment – or placement in other housing options outside of SAPC's network is more appropriate. If non-RBH is assessed to be more appropriate, SUD providers should work with appropriate staff at CES lead agencies to match homeless individuals with available housing for which they are eligible based on their VI-SPDAT score.

Eligibility for Recovery Bridge Housing

RBH is available for *adults* who meet all of the following criteria:

1. In need of a stable, safe living environment in order to best support their recovery from a SUD.
2. Belongs to one of the prioritized populations (see Table 12).
3. Concurrently enrolled in treatment in OP/IOP/OTP/OP-WM treatment settings.

Individuals appropriate for RBH may be stepping down from residential treatment, or may be entering the SUD treatment system directly in OP/IOP/OTP/OP-WM levels of care. RBH for Transitional Age Youth (ages 18- 25) may also be available for eligible individuals who need a developmentally and age appropriate living environment. Youth (under age 18) who require recovery housing may be eligible for placement in a group home that provides treatment and ancillary services on sites licensed by the California Department of Social Services.

Patients must be concurrently enrolled in treatment in order to receive RBH subsidies. Those who are discharged from treatment in OP/IOP/OTP/OP-WM settings will no longer be eligible to receive the subsidy for Recovery Bridge Housing.

Certain populations will be prioritized for RBH (see Table 12) and SAPC will develop an electronic prioritization system to facilitate RBH placement. Populations other than the prioritized populations will only be authorized for RBH if sufficient capacity is available to accommodate prioritized populations.

Recovery Bridge Housing Considerations and Authorization Process

While some SUD patients prefer to live in abstinence-focused housing to help support their recovery in sober living environments, others who are not yet ready or able to maintain abstinence prefer a low barrier, harm reduction approach. Individuals being considered for RBH should have chosen to be placed in an abstinence-based living environment in order to facilitate their recovery. Subsequently, SUD providers should discuss housing preferences with patients, and combined with their professional judgment, determine if housing in RBH or placement in other housing options outside of SAPC's network is more appropriate.

All patients being considered for RBH should first be screened for alternative access to housing through some other mechanisms (e.g. Probation provides access to recovery residences and other housing options to AB 109 patients). Some individuals may be eligible for or receiving a subsidy to pay for recovery housing from a funding source outside of the SUD system, such as AB 109 funding. Since RBH cannot be paid for with DMC funds, SAPC network providers should make every effort to match patients with appropriate recovery housing subsidized by another funding source whenever possible.

If RBH is determined to be appropriate, SAPC providers must submit an authorization request form and supporting documentation to the UM Unit in order to receive a subsidy for RBH from SAPC. UM staff will review the authorization request form and supporting documentation (e.g., full ASAM assessment,

treatment plan, progress notes, and discharge/transfer plan), and render a decision on authorization of the RBH subsidy. Referring providers must document the need for RBH in the patient's treatment plan.

Duration of Recovery Bridge Housing

SAPC may authorize and subsidize up to a maximum of ninety (90) calendar days of RBH per calendar year for patients who meet the eligibility criteria specified above. Individuals who do not utilize the entirety of the ninety (90) calendar days during the year may use the remainder of the unused days later during the calendar year, as necessary.

Perinatal patients may be eligible for lengths of stay in RBH up to the length of the pregnancy and postpartum period – the last day of the month in which the 60th day after the end of the pregnancy based on medical necessity

Eligible Recovery Bridge Housing Providers

Currently, RBH providers are limited to current SAPC contracted providers with at least three (3) years of experience providing RBH to individuals receiving treatment in OP/IOP/OTP/OP-WM settings.

In summary, when paired with sufficient treatment and supportive services, and a complementary continuum of housing options to meet the varied needs of the SUD population, RBH is a crucial component to facilitate recovery.

Recovery Support Services

Recovery is a personal process that is built on an individual's strengths, coping abilities, resources, and values. Recovery should be holistic, addressing the whole person within their community. It is characterized by continual growth and improvement in one's health and wellness that may involve setbacks that are a natural part of life. Resilience and the ability to cope with adversity and adapt to challenges or change are also key components of recovery. Resilience develops over time and gives an individual the capacity not only to cope with life's challenges, but also to be better prepared for the next stressful situation.

SAMHSA has outlined four major dimensions that support a life in recovery:

- **Health** - overcoming or managing one's disease(s) or symptoms—for example, reducing harmful use of alcohol, illicit drugs, and non-prescribed medications if one has a substance use problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being.
- **Home** - having a stable and safe place to live.
- **Purpose** - conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- **Community** - having relationships and social networks that provide support, friendship, love, and hope.

Recovery support services (RSS) refer to services that foster health and resilience in individuals and families by helping them to navigate systems of care, and reduce barriers to employment, housing, education, and other life goals. They are developmentally, culturally, and linguistically appropriate, and

facilitate securing necessary social supports, remaining engaged in the recovery process, and living full and healthy lives in communities of their choice. They incorporate a broad range of support and social services that facilitate recovery, wellness, and linkage to and coordination among service providers, with the greater goal of improving the quality of life for people in and seeking recovery.

The ASAM criteria's multidimensional assessment includes Dimension 6, which assesses the recovery environment of the individual and helps to identify specific recovery needs that should be supported by RSS. Substance use providers, physical and mental health providers, peer providers, family members, friends and social networks, and the faith community may provide recovery support services. They may be provided wherever patients obtain services and can occur during treatment or as aftercare. In accordance with the chronic disease model and the fact that recovery is often a lifelong journey rather than a final destination, SUD treatment should not end when the treatment episode ends. Similar to the manner in which patients frequently see their primary care provider for periodic health checkups even when healthy, RSS can be viewed as continuity of care in SUD treatment. The frequency of RSS should be dependent on patient need, preference, and where an individual is in their stage of recovery.

Because of its individualized nature, RSS may include a number of different services and approaches:

- **Recovery Monitoring -** Recovery monitoring by recovery coaches and/or care navigators help individuals become and stay engaged in the recovery process and reduce the likelihood of relapse. These services can effectively extend the continuum of care beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery. Utilizing a recovery management model, the recovery coach or care navigator functions as the primary and ongoing point of contact for patients in order to follow up with patients on a regular basis and monitor their recovery status. As needed, recovery coaches and care navigators may provide patients with linkages to educational and job skills, housing and transportation, self-help and support, and spiritual and faith-based supports, depending on the patient's preference. Recovery coaching and/or care navigation encounters may occur via in-person meetings telephone, text messages, and/or Internet.
- **Substance Abuse Assistance -** Peer-to-peer services and relapse prevention.
- **Education and Job Skills -** Linkages to life skills, employment services, job training, and education services.
- **Family Support -** Linkages to childcare, parent education, child development support services, and family/marriage education.
- **Support Groups -** Linkages to self-help and support, spiritual and faith-based support.
- **Ancillary Services -** Linkages to housing assistance, transportation, case management, individual services coordination.

Recovery residences are a broad term describing a safe, sober, and healthy living environment that promotes recovery from alcohol and other drug use. The purpose of a recovery residence is to provide a living environment conducive to initiating and sustaining recovery. There are many different types and variations of these settings with different levels of support, providing a spectrum of housing to best meet the unique and dynamic needs of individuals across the stages of recovery. The services provided at recovery residences vary, and include peer support, group and house meetings, self-help, life skills development, treatment services (excluding treatment services that require a DHCS residential license), among other recovery-oriented services. Recovery residences must meet all zoning, fire clearance and other local requirements.

Patients who no longer meet medical necessity criteria for SUD treatment services, or prematurely exit the SUD system of care, should receive recovery monitoring services for a minimum of 6 months by the last treatment provider of care, who will reengage the individual in treatment if needed. The frequency of recovery monitoring contacts should depend on the individualized recovery situations of patients. For example, patients who have just exited SUD treatment and those at higher risk for relapse should generally receive more recovery monitoring contacts than those who have been in sustained recovery.

Case Management / Care Coordination[WW1]

Case management is a coordinated approach to the delivery of health and social services, linking patients with appropriate services to address specific needs and achieve stated goals. At its core, case management should be comprised of several key functions: assessment, planning, linkage, monitoring, and advocacy.

Providers will provide case management services and will be able to bill for these services. Various members of the treatment team can function as the case manager, including registered/certified SUD counselors, social workers and Marriage and Family Therapists (MFTs), nurses, physicians, etc. Case management services may be provided face-to-face, by telephone, or by telehealth with the patient and may be provided anywhere in the community.

Research suggests two main reasons why case management is effective as an adjunct to substance abuse treatment: 1) retention in treatment is associated with better outcomes, and a principal goal of case management is to keep patients engaged in treatment and moving toward recovery; and 2) treatment may be more likely to succeed when a patient's other problems are addressed concurrently with substance abuse.

Case managers must have a working knowledge of the appropriate services needed for the patient to optimize care through effective, relevant networks of support.

In order to link patients with services and resources (e.g., financial, medical, or community services), case managers must have a working knowledge of the appropriate services needed for the patient to optimize care through effective, relevant networks of support. Case managers provide assistance with accessing transportation, securing safe housing, and looking for potential employment and vocational training opportunities, particularly in geographic locations convenient for the patient. Skill development services help the patient learn how to budget, plan meals, practice hygiene and personal care, and perform housekeeping. Services provided through case management are thus tailored to facilitate continuity of care across all systems of care, and provide extensive assessment and documentation of the patient's progress toward self-management and autonomy.

Although an important component of case management in the SUD population is linking patients to outside systems of care, such as physical and mental health systems, these services are equally important in navigating patients through the SUD system of care. Comprehensive substance abuse treatment often requires that patients move to different levels of care within the SUD continuum, and case managers help to facilitate those transitions. When implemented to its fullest, case management enhances the scope of addiction treatment and the recovery continuum.

Case management may be provided face-to-face or telehealth, including via telephone. Guiding principles of comprehensive case management include:

- Comprehensive assessments and periodic reassessments of patients to determine service needs.
- Aiding in transitions in care, both within the SUD system of care and between physical and mental health systems.
- Ensuring ongoing source of primary care.
- Using a patient-centered, collaborative approach to address the medical, psychosocial, behavioral, and spiritual needs of the patient, and improve treatment retention.
- Promoting advocacy, shared decision-making, and education by moving the individual to self-management and autonomy through community resources and linkages.
- Participating in communication, coordination, referral and related activities.
- Coordinating services furnished to a patient with services the patient receives from any other plan.
- Sharing the results of assessment with plans serving a patient with special health care needs to prevent duplication of activities.
- Using culturally competent and evidence-based practices in the daily practice of case management.
- Promoting quality outcomes that measure and improve patient safety, satisfaction and other dimensions of optimal health and well-being.
- Protecting confidentiality and privacy in accordance with HIPAA and 42 CFR Part 2 privacy requirements.
- Maintaining and reinforcing compliance with federal, state, local rules and regulations.

Performance and Outcome Measures

Healthcare providers, including SUD providers, share the common goal of providing high quality care. Measuring performance and outcomes help organizations and providers understand how well they are accomplishing this goal and allows for an analysis of where and what changes need to be made in the process of striving for continual improvement. Providers are required by contract to have ongoing mechanisms for quality assessment and performance improvement. Metrics also allow providers to understand what is working well so that others can learn from their success. Assessing and evaluating performance and outcome measures is consistent with the Department of Public Health's Performance Management System (see Figure 3).

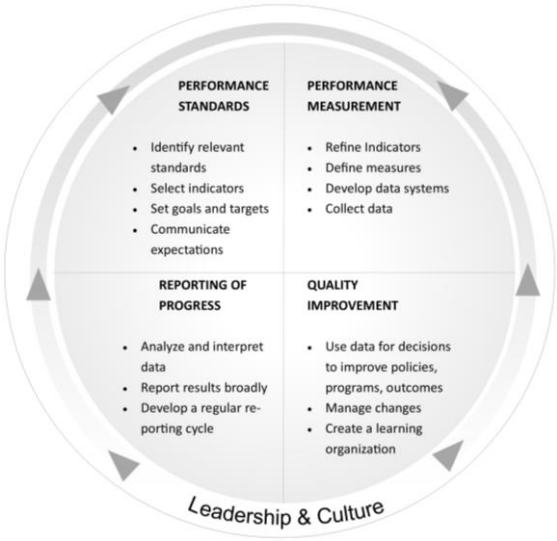
Importantly, performance and outcome measurement differ as follows:

- Outcome measures are used at the patient level to examine changes in substance use behaviors and psychosocial functioning. They are used to understand the effectiveness of treatment services in improving substance use and related functioning of *individuals* who have received treatment.
- Performance measures are used at the program level to evaluate how well a program is doing in achieving standards of quality, and can help identify where service problems exist, which programs are meeting or exceeding expectations of treatment quality, and what, if any, changes should be made to improve service delivery. They inform quality improvement strategies aimed at changing *clinical practices* and *organizational cost management*.

Although SAPC recognizes that performance and outcome measurement in the field of addiction is challenging due to the nuances of clinical care that are not always reflected in the measures, and that consensus standards need to continue to improve, there is also a recognition of the important role that this will play in moving the field ahead. As a result, SAPC has worked with UCLA and stakeholders to develop an inventory of measures that will be used as part of the Continuous Quality Improvement (CQI and UM) process. The SUD Measure Inventory includes a compilation of performance and outcome

measures that are derived from national experts on quality improvement and performance measurement, such as the National Quality Forum, National Committee on Quality Assurance, The Washington Circle, and UCLA, among others.

Figure 3. **Public Health Performance Management System**



The process of striving for quality and continual improvement is dependent on the ability to measure performance and outcomes.

The SUD Measure Inventory includes performance and outcome measures that highlight key areas of interest, such as prevention, penetration rates, access, treatment outcomes, care continuity, integrated care, patient-centered care, medication-assisted treatment, functional improvement, and agency level metrics. To address patient perception of care (patient satisfaction), SAPC will use the Modular Survey [GT2]developed by SAMHSA's Center for Substance Abuse Treatment. The survey measures consumer perceptions of their experience during treatment in the area of access, quality, social connectedness, and commitment to change.

In addition to these more clinical measures, SAPC has also worked with UCLA and stakeholders to develop a set of research measures that allow for the review of treatment data in order to identify areas that require additional study, training, or technical assistance. These research measures, in conjunction with the SUD Measure Inventory, help to ensure that Los Angeles County has an evaluation system that allows for continuous improvement and high quality clinical care at the provider and systems level.

SAPC will work to automate the data collection process to the extent that is possible, but data entered by providers will continue to be critical to ensure high quality data. Given that this data will inform policy and ultimately impact clinical practice, ensuring data integrity is to the benefit of both SAPC and its providers, and providers are expected to develop internal processes to support data integrity efforts.

SAPC recognizes the importance of sharing performance and outcomes data with its provider network, and will make every effort to provide metrics to assist providers in their quality improvement efforts. The sharing of performance and outcomes data with providers will include patient satisfaction information and other meaningful issues that pertain to clinical care.

Given the continual evolution of the field of addiction treatment, the SUD Measure Inventory will evolve with the availability of new information and research, and is subject to ongoing review.

Peer Review

Provider agencies must incorporate peer reviews into their continuous quality improvement activities, and establish a formal process for regularly identifying processes or variations in care/services that may lead to undesirable or unanticipated events affecting patients or clinical care. The goal of the peer review process is to establish an educational and evaluative mechanism for providers to contribute to the identification of opportunities to improve care and services.

As a component of the peer review process, SUD counselors/clinicians of various disciplines review their colleagues' patient charts and provide feedback on the care that is recommended and provided, in a professional and non-adversarial manner. Reviews should be performed by practitioners within their appropriate scope of practice, and when possible, supervisors should review and follow up with counselors/clinicians in order to provide feedback based on the peer review process. Analyses of clinical decisions and practices should be based, as appropriate, on objective evidence drawn from relevant scientific literature, clinical practice guidelines, departmental historical experience and expectations, peer department experience and standards, and national standards.

The focus of these reviews may vary depending on needs determined by the provider agency, and may highlight an individual event or aggregate data and information on clinical practices. However, at a minimum, peer reviews must include:

- Review of diagnosis/diagnoses and assessment(s).
- Review of documentation clarity and organization.
- Ensure treatment plans are documented and updated accordingly.
- Ensure documentation is signed by appropriate individuals.

The quantity and frequency of reviews may also vary depending on needs determined by the provider agency for each site, but no less than three (3) patient charts for each counselor/clinician must be reviewed twice annually.

All records and information obtained during peer review functions should remain confidential and be used only for the purpose of reviewing the quality and appropriateness of care for improved practices.

Quality Improvement Projects

A quality improvement project (QIP) is a concentrated effort on an identified problem in one area of a provider agency. It involves gathering information systematically to identify and clarify issues or

problems, and intervening for improvements. The purpose of QIPs is to examine and improve care or services in high-priority areas that the agency identifies as needing attention, which will vary depending on variables including, but not limited to, the population served, workforce, and unique scope and capabilities of services provided. The QIP is not meant to replace other quality improvement projects that organizations may already be using, which may be used or adapted to qualify as their QIP.

All QIPs should follow the Continuous Quality Improvement model and target improvement in relevant areas of clinical care, either directly or indirectly. Areas of focus may include improving access to and availability of services, improving continuity and coordination of care, improving the quality of specific interventions, enhancing service provider effectiveness, etc. Generally, a clinical issue selected for study should impact a significant portion of the patient population served and have a potentially significant impact on health, functional status or satisfaction. Over time, areas selected for improvement focus should address a broad spectrum of care and services.

Each provider agency must be involved in at least one QIP at all times, and these projects and their evolution will be reviewed on an annual basis by SAPC staff.

Confidentiality

All programs must operate in accordance with legal and ethical standards. Federal and state laws and regulations protect the confidentiality of patient records maintained by all SAPC contracted providers. Maintaining appropriate confidentiality is of paramount importance. All SAPC contracted providers are required by contract to establish policies and procedures regarding confidentiality and must ensure compliance with Title 42, Chapter I, Subchapter A, Part 2 of the Code of Federal Regulations, Part 2 (42 CFR Part 2), the Health Insurance Portability and Accountability Act (HIPAA) standards, and California State law regarding confidentiality for information disclosure of alcohol and drug use, and other medical records.

HIPAA and 42 CFR Part 2 both cover what information can be disclosed with and without patient permission, as well as exceptions to confidentiality (e.g., emergency care, evaluation, research and audit activities).

- For a summary of 42 CFR Part 2, please see: http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2 - se42.1.2_131
- Subpart A includes an introduction to the statute (e.g., purpose, criminal penalty, reports of violations, etc).
- Subpart B covers general provisions (e.g., definitions, confidentiality restrictions, and minor patients, etc).
- Subpart C covers disclosures allowed with the patients' consent (e.g., prohibition on re-disclosure, disclosures permitted with written consent, disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs, etc).
- Subpart D covers disclosures that do not require patient consent (e.g., medical emergencies, research, evaluation and audit activities).
- And Subpart E includes information on court orders around disclosure (e.g., legal effects of order confidential communications, etc).
- A summary of the HIPAA privacy rule can be found here: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html. For more general information on HIPAA, please see: http://www.hhs.gov/ocr/privacy/index.html. For more specific

information concerning covered entities, consumer information and health information technology, please see http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html.

These laws and regulations must not be used as barriers to provide coordinated and integrated care. Provided that the appropriate patient releases and/or consents for treatment are obtained, every effort should be made to share clinical information with relevant providers across the continuum of SUD care, and also across systems of care (physical and mental health, etc). Within the requirements of the laws and regulations governing confidentiality in the provision of health services, all SAPC contracted providers must cooperate with system-wide efforts to facilitate the sharing of pertinent clinical information for the purposes of improving the effectiveness, integration, and quality of health services.

Risk Management

Risk management refers to strategies that minimize the possibility of an adverse outcome or a loss, and maximize the realization of opportunities. Good risk management techniques improve the quality of patient care and reduce the probability of an adverse outcome and resulting liability to the health care provider. Standards of care, quality improvement, and the systematic gathering, analysis, and utilization of data are the foundations of risk management.

Good risk management techniques improve the quality of patient care and reduce the probability of an adverse outcome and resulting liability to the health care provider.

SAPC recognizes the growing need and importance of risk management strategies in an evolving health care landscape. As a result, each provider agency providing services within SAPC's network is responsible for investigating and reporting on specific functions and aspects of care dealing with risk management issues, including reviewing reportable incidents and adverse events, verifying service/billing integrity, and establishing peer review processes among service providers.

Adverse events are defined as incidents that have a direct or indirect impact on the community, patients, staff, and/or the provider agency as a whole need to be investigated and evaluated at the provider agency level. This information should be used on a routine basis to improve accessibility, health and safety, and address other pertinent risk management issues. The functions and responsibilities of the providers' Risk Management Committee should be systematic and ongoing to include appropriate and timely responses for addressing areas of concern or deficiency.

Reportable incidents are patient safety events that result in death, permanent harm, and/or severe temporary harm, and intervention required to sustain life. Reportable incidents must be investigated by the provider's Risk Management Committee, and must be reported to the SAPC Quality Improvement/ Risk Management Committee immediately. These incidents may result in corrective actions and are viewed as learning opportunities to improve care and risk management processes.

While reportable incidents must be reported to the SAPC Quality Improvement/Risk Management Committee, adverse events and other risk management and quality-related issues may be reported to SAPC at the discretion of the leadership of contracted providers.

Overall, the functions and responsibilities of the providers' Risk Management Committee should be systematic and ongoing to include appropriate and timely responses for addressing areas of concern or deficiency. The goals of the provider Risk Management Committees may include:

- To assure implementation of an agency-wide safety program that includes development of policies and procedures, and subsequent staff trainings, relating to quality improvement, fire safety, disaster preparedness, hazard reporting, etc.
- To assure a tracking and documentation system for all reportable incidents, including follow up and implementation of any corrective action until follow up is no longer indicated.
- To review safety and incident related data and to identify trends and patterns associated with risks or to identify problem areas.
- To investigate adverse events, as necessary and appropriate.
- To provide thorough investigation on all reportable incidents, which must be reported to SAPC.
- To establish processes to maintain service/billing integrity and quality care, including peer review processes for service providers.
- To promote quality improvement activity through identifying opportunities towards maximizing safety of physical and therapeutic environment and reducing agency, staff, and patient risks.

UTILIZATION MANAGEMENT PROGRAM

The Utilization Management (UM) program analyzes how the SAPC provider network is delivering services and how it is utilizing resources for eligible patients. The various responsibilities of the UM program include: ensuring adherence to established DMC eligibility verification and medical necessity criteria; ensuring that clinical care and ASAM level of care guidelines are followed; monitoring both under- and over-utilization of services; assessing the quality and appropriateness of care furnished to enrollees with special health care needs; conducting clinical case reviews (prospective/concurrent/retrospective) of requests for select services; authorization of select services; random and retrospective monitoring of a portion of provider caseloads; and ongoing monitoring and analysis of provider network service utilization trends.

SAPC follows federal and state decision and notification timeframes for all UM determinations.

In summary, the purpose of the UM program is to achieve the following objectives for patients and providers:

- To assure effective and efficient utilization of facilities and services through an ongoing monitoring program designed to identify patterns in under-utilization, over-utilization, and inappropriate utilization of services across the service continuum.
- To assure fair and consistent UM decision-making.
- To focus resources on a timely resolution of identified problems.
- To assist in the promotion and maintenance of optimally achievable quality of care.
- To educate health care professionals on appropriate and cost-effective use of health care resources.

SAPC follows federal and state decision and notification timeframes for all UM determinations. SAPC will make every effort to complete UM determinations expeditiously in order to facilitate timely treatment for the patients served in the system of SUD care in Los Angeles County, and to assure compliance with all requirements.

DMC Eligibility Verification and Medical Necessity Review Process

Initial DMC eligibility verification should occur at the point of first contact between a patient and the SUD system of care, whether it be the Beneficiary Access Line or at the treatment provider site. Medical necessity determinations will occur at the provider site. The initial DMC eligibility verification may be performed by trained support staff and/or registered or certified SUD counselors, however medical necessity determinations must be performed by a Medical Director, licensed physician, or Licensed Practitioner of the Health Arts (LPHA) (see Workforce section above).

Initial DMC eligibility verification requirements for patients:

- Resides within Los Angeles County.
- Must be enrolled in Medi-Cal.
- Must meet medical necessity criteria for adults or adolescents, respectively (see Medical Necessity section for additional details).

Initial DMC benefit verification may be performed by trained support staff and/or registered or certified SUD counselors, however medical necessity determinations must be performed by a Medical Director, licensed physician, or Licensed Practitioner of the Health Arts (LPHA).

Benefits for SUD services shall be available to all patients who meet the requirements of the DMC eligibility verification and medical necessity criteria listed above. Legal status (e.g., parole, probation) is not a barrier to access substance use services, provided that the prospective patient meets the specified DMC eligibility verification and medical necessity requirement.

Ongoing DMC eligibility verification will be determined by medical necessity assessment at least every six (6) months through the reauthorization process for all SUD services other than Opioid Treatment Program services, which require DMC verification every twelve (12) months. During the reauthorization process, the Medical Director, licensed physician, or LPHA at the provider agency will be required to justify ongoing eligibility for services by requesting DMC eligibility verification and submitting clinical documentation including current treatment plan, assessment information, progress notes, and laboratory test results (if available).

All documentation should be submitted at least twenty-one (21) calendar days in advance of end date of current DMC eligibility verification in order to prevent the disruption of reimbursable services. The provider agency will be notified of the DMC eligibility re-verification decision within the timeframe listed in Table 13.

After the initial DMC eligibility verification and medical necessity determination, UM staff will perform a patient case review in situations that require authorization or preauthorization in order to verify that these criteria have been met prior to payment for services. For other cases that do not require authorization or preauthorization, as a component of the UM program, a random retrospective review of a portion of all provider caseloads will also ensure fidelity to verification of DMC eligibility and medical necessity criteria.

UM staff have the authority to approve services and reimbursement. If the decision is outside the scope of the UM staff member's authority, the case will be referred to UM management and/or the Medical Director or qualified designee for a determination.

Information for case reviews is obtained from a variety of sources. Although each case is unique, these sources of information may include, but are not limited to, information from the patient or responsible

family member, patient record, substance use providers, physical/mental health providers, etc. Utilization Management staff will use this information, along with clinical judgment, departmental policies and procedures, needs of the patient, recommendations from providers, and characteristics of the system of care, to render a decision about the provision of SUD services, as needed.

If UM staff determines that DMC eligibility verification and medical necessity criteria have been met, and the proposed or provided services are deemed clinically appropriate, services and reimbursement will be authorized and the applying agency will be notified in accordance with the notification timeframes listed in Table 13. Reimbursements for services will be retroactive to the date of the referral submission, pending case review and approval.

If UM staff render a denial determination for DMC eligibility and medical necessity, the case will be reviewed by supervisorial staff within the UM program. If the decision is consistent with the original denial, the applying agency will be notified of the denial decision within the timeframes listed in Table 15.

Adverse DMC eligibility and medical necessity determinations will result in denial of reimbursement for services rendered. Denial notifications will include information including, but not limited to:
- Reason(s) including specific plan provisions, clinical judgment used.
- Any additional information needed to improve or complete the claim.
- Descriptions of the appeal process.

Patients, or providers acting on behalf of the patient, have the opportunity to review and respond to the evidence and rationale outlined in the initial denial, and may challenge a denial of DMC eligibility, coverage of services, or denial of payment for services (see Grievances and Appeal Process).

Table 13. Utilization Management Notification Timeframes

Review Type	Email/Verbal Decision Notification	Written Decision Notification
INITIAL AUTHORIZATIONS and VERIFICATIONS		
Initial Preauthorization for: - **Residential Services** (*for both adults and youth*)	Within twenty-four (24) hours of receipt of request	Within five (5) calendar days of receipt of request
Verification of DMC Eligibility	Within twenty-four (24) hours of receipt of request	Within five (5) calendar days of receipt of request
Initial Authorization for: - **Recovery Bridge Housing** (*only for adults*) - **Medication-Assisted Treatment for Youth under age 18** - **Withdrawal Management Services for Youth under age 18** **Must submit authorization requests for these services within three (3) calendar days	Within five (5) calendar days of receipt of authorization request	Within seven (7) calendar days of receipt of authorization request

after patient's admission to the treatment program		
RE-AUTHORIZATIONS		
Reauthorization of: - **Residential Services** - **Recovery Bridge Housing for perinatal patients every 30 calendar days until 60 days after the end of the pregnancy** ** Must submit re-authorization request at least seven (7) calendar days in advance of end date of current authorization	Within five (5) calendar days of receipt of re-authorization request	Within seven (7) calendar days of receipt of re-authorization request
Re-Authorization for: - **Medication-Assisted Treatment for Youth under age 18** - **Withdrawal Management Services for Youth under age 18** * Must submit reauthorizations at least twenty-one (21) calendar days in advance of end date of current authorization or verification **There is no reauthorization necessary for withdrawal management services.	Within fourteen (14) calendar days of receipt of re-authorization for non-residential services and/or re-verification for DMC eligibility request	Within twenty-one (21) calendar days of receipt of re-authorization request for non-residential services and/or DMC eligibility verification
Re-verification of DMC eligibility * Must submit re-verification requests at least twenty-one (21) calendar days in advance of end date of current authorization or verification	Within fourteen (14) calendar days of receipt of re-authorization for non-residential services and/or re-verification for DMC eligibility request	Within twenty-one (21) calendar days of receipt of re-authorization request for non-residential services and/or DMC eligibility verification
EXPEDITED AUTHORIZATIONS OR VERIFICATIONS		
If provider indicates or the UM team determines that following the standard authorization timeframe could seriously jeopardize the patient's life, health, or functional status → Expedited authorization process	As expeditiously as the patient's health condition requires and no later than three (3) business days	N/A

Note:

- These timeframes are only applicable after sufficient information is obtained by UM staff to make a determination. In other words, the clock for these timeframes will not start until UM staff receive sufficient information to make an authorization or verification decision.

- These timeframes may be extended by up to an additional fourteen (14) calendar days if:
  - The patient or the provider, requests extension.
  - SAPC justifies (to the State agency upon request) a need for additional information and how the extension is in the patient's interest.
- Providers must submit request for preauthorized residential services prior to initiation of services, unless providers elect to provide the service prior to receiving preauthorization, and accept financial loss if the preauthorization is ultimately denied.
- Any request for Authorization may be denied due to untimely submission (e.g., not submitted in accordance with the timeframes specified above.

Clinical Case Review Process

Utilization Management staff will review clinical cases from SAPC providers, including both adolescent and adult patients. The purpose of these case reviews is to establish an ongoing monitoring program to ensure appropriate and quality care, as well as appropriate utilization of services across the SUD service continuum. In some instances, these reviews are related to reimbursement of services and in others, the reviews are important and necessary to ensure the quality and appropriateness of services provided. Providers contracted to provide services with SAPC are required to cooperate with all case reviews conducted by the UM program. These reviews are independent from, but complementary with, SAPC contract monitoring activities.

Utilization Management staff will review clinical cases from SAPC's network of providers in order to establish an ongoing monitoring program to ensure appropriate and quality care, as well as appropriate utilization of services across the service continuum.

Multidisciplinary UM reviewers will possess appropriate clinical expertise to evaluate the case and will conduct thorough case analyses, assess for appropriate care that is consistent with generally accepted standards of clinical practice, and determine appropriate utilization of services and resources to ensure that patient needs are met. Reviewers will conduct additional research, discuss the case with the requesting provider when appropriate, and consult the ASAM criteria and/or other appropriate resources.

Information for case reviews is obtained from a variety of sources. Although each case is unique, these sources of information may include, but are not limited to, information from the patient or responsible family member, patient record, substance use providers, physical/mental health providers, etc. Utilization Management staff will use this information, along with clinical judgment, departmental policies and procedures, needs of the patient, recommendations from providers, and characteristics of the local delivery system, to render a decision about the provision of SUD services.

Case review considerations include, but are not limited to:
- Patient/family/guardian identified goals and preferences.
- Care/service is necessary and clinically appropriate in terms of level of care, intervention, frequency, timing, and duration, and considered effective to promote recovery.
- Care/service is consistent with generally accepted standards of clinical practice based on:
  - Credible scientific evidence published in peer-reviewed medical literature that is generally recognized by independent clinical experts at the time the services are provided.
  - Recommendations of a physician-specialty society.
  - Up-to-date diagnostic criteria from the most current DSM and ASAM criteria.
  - Case discussions with treating providers, when appropriate.

  - Any other relevant factors.
- Case management to ensure that care/service is coordinated both across the continuum of SUD care and across relevant physical and mental health systems, as clinically indicated.
- Regular patient assessments ensure that care/service is provided in the least restrictive, most cost-effective environment that is consistent with clinical standards of care.
- Care/service is not provided solely for the convenience of the provider, recipient, recipient's family, or custodian (e.g., placing patients in a residential level of care primarily for housing purposes).
- Care/service is not experimental, investigational, and/or unproven.
- Care/service is deemed necessary and furnished by or under the supervision of an appropriate and authorized licensed practitioner, and in accordance with all applicable rules, regulations, and other applicable federal, state, and local directives.

Provider caseloads for adults and adolescents at each ASAM level of care will be randomly and retrospectively reviewed on at least an annual basis, in addition to the cases that require authorization and preauthorization (described below). These case reviews are independent from SAPC contract monitoring activities, and the quantity of these reviews will occur at County discretion. Utilization Management staff may also conduct focused, retrospective chart reviews whenever concerns arise about a particular provider or patient. Such reviews may be conducted on site and without prior notice to the provider. As needed, Utilization Management and Contracts staff will confer on cases to determine the most appropriate responding SAPC entity. These cases will then be addressed, as appropriate.

Services that require preauthorization, such as residential services (for both adults and youth), are services for which the treating provider must request approval before initiating treatment and/or before continuing care for an extension of a previous authorization.

However, if relapse risk is deemed to be significant without immediate placement in these levels of care, treatment providers may admit an individual prior to receiving preauthorization, with the understanding that preauthorization denials will result in financial loss, whereas preauthorization approvals will be retroactively reimbursed to the date of admission.

The following methods of review are utilized by UM staff:

- **Prospective Review -** A prospective review occurs prior to the delivery of the services and applies to an initial request or for services that require authorization. The prospective review is performed by UM reviewers, who apply pre-established medical necessity/appropriateness criteria and render a decision on approval or denial of authorization and/or reimbursement.
  - Prospective reviews allow for the opportunity to assure the efficient and appropriate provision of care and utilization of resources, and to continually assess and improve access and quality of care.
  - Example of prospective review:
    - Preauthorization of residential services.
- **Concurrent Review -** A concurrent review examines ongoing care to evaluate medical necessity, and the quality and appropriateness of care. This review is conducted by UM reviewers, in accordance with pre-established criteria, as previously mentioned.
  - The main objectives of the concurrent review process are to ensure that care is appropriate and in accordance with generally accepted standards of practice, to continually monitor patient progress, and to anticipate treatment needs and transitions that promote recovery. Examples of concurrent review:
    - Authorization of MAT and withdrawal management for patients under age 18
    - Authorization of Recovery Bridge Housing
    - Reauthorization of ongoing MAT for patients under age 18.
    - Reauthorization of ongoing residential services.
- **Retrospective Review -** Retrospective reviews examine various aspects of previously provided services. These reviews yield information about the quality of verification of DMC eligibility and

service authorization decisions, and other aspects associated with the services provided to patients. This information is used to evaluate the quality and appropriateness of the services the provider is contracted to deliver. Open and closed cases may be identified for retrospective review through numerous mechanisms.

- Retrospective reviews allow for the opportunity to identify under- and over-utilization of services, to identify utilization patterns and trends, to continually evaluate the consistency of the UM review and decision-making process, and to continually identify areas of improvement.
- Example of retrospective review:
  - Random, focused chart review of services that have already been rendered to ensure fidelity to verification of DMC eligibility and medical necessity criteria, as well as quality of care.

The UM program utilizes a variety of methods of review when performing case reviews to monitor care quality and appropriateness, and to inform decisions regarding verification of DMC eligibility, coverage of services, and authorizing reimbursements. Given the complications that can result from the denial of retrospective reviews after the provision of services by providers, whenever possible, prospective and concurrent reviews are preferable to retrospective reviews. The timely submission of authorization requests by providers is helpful in minimizing the potential complications and financial impact of retrospective review denials, and is therefore beneficial to the submitting provider.

Types of Preauthorized and Authorized Services

Preauthorized Services

Services requiring preauthorization are services for which the treating provider must request approval before initiating treatment. In these instances, UM staff will perform prospective reviews of care that has yet to be provided and concurrent reviews of extensions of previous authorizations, when pertinent.

The provider will be required to notify UM staff of the recommended services electronically via SAPC website or fax in order to begin the preauthorization review process. Notifications from providers must, at a minimum, include a completed Authorization Request Form and initial intake documentation, including assessment information. Providers must submit application for preauthorized residential services prior to initiation of services, unless providers elect to provide the service prior to receiving preauthorization, and accept financial loss if the preauthorization is ultimately denied. Requests for continuation of services that require preauthorization must be submitted at least seven (7) calendar days in advance of the end date of current authorization, and required documentation includes, at a minimum, a completed Authorization Request Form, current treatment plan, assessment information, and progress notes, and laboratory test results (if available).

UM staff will perform clinical reviews of the case being referred for preauthorization, based on the case review considerations listed above. Approval for initial preauthorization requests is based on medical necessity and ASAM Level of Care guidelines, as well as generally accepted standards of clinical practice. Consideration for ongoing authorization is based on the same criteria, as well as documented progress and engagement in treatment.

If a decision determination cannot be made due to insufficient documentation, UM staff will return the authorization request and notify the provider that additional information is needed to process the request.

For services that require preauthorization, notifications will occur within the prospective and concurrent review timeframes specified in Table 13.

Clinical scenarios that require preauthorization, and relevant service-specific details, include:

- **Residential services (*preauthorization required for both adults and youth*):**
    - The provider will submit a preauthorization request to the UM unit, which will conduct a prospective review, and then approve or deny the request within 24 hours of receiving the request.
    - **If relapse risk is deemed to be significant without immediate placement in residential care, a residential treatment provider may admit an individual prior to receiving residential preauthorization, with the understanding that preauthorization denials will result in financial loss, whereas preauthorization approvals will be retroactively reimbursed to the date of admission.**
    - Requests for continuation of residential services must be submitted at least seven (7) calendar days in advance of the end date of current authorization.
    - Residential preauthorizations pertain to the provision of all residential services, including youth, adults, perinatal patients, and criminal justice involved patients.
    - Residential preauthorizations are only required when initiating residential care or transitioning from non-residential to residential levels of care. Residential reauthorizations are not required for transitions between residential levels of care (e.g., either transitions up or down between residential levels), although a notification must be sent to SAPC within three (3) calendar days of the transition.
    - Residential lengths of stay:
        - Adults
            - Initial residential preauthorizations for adults will authorize no more than sixty (60) calendar days at the outset of residential services. In other words, residential services for all adult populations require reauthorization after sixty (60) calendar days to assess for appropriate level of care utilization, if adult clients are determined to require longer lengths of residential care.
            - For adults, the length of residential services range from one (1) to ninety (90) calendar days with a ninety (90) calendar day maximum, unless medical necessity authorizes a one-time extension of up to thirty (30) calendar days on an annual basis.
            - For adults, one extension of residential services up to thirty (30) calendar days beyond the maximum length of stay of ninety (90) calendar days may be authorized for one continuous length of stay in a one-year period (365 calendar days).
            - Residential Grace Period – Adults
                - For adults, while DMC reimbursable residential admissions are limited to only two non-continuous ninety (90) calendar day residential admissions during a one-year period, SAPC will implement a seven (7) calendar day grace period by which the residential stay for adult patients who leave (e.g., drop out) or are administratively discharged (e.g., kicked out for reason) from residential treatment within seven (7) calendar days will be reimbursed with non-DMC funds. This will help preserve the two allowable DMC reimbursable residential admissions per year.

- An adult patient's first residential admission will always be paid for via DMC, even if less than seven (7) calendar days. However, the residential grace period will apply for subsequent residential admissions with no cap (e.g., the residential grace period applies for all residential admissions beyond the first admission).

- Special Adult Populations
  - Perinatal clients
    - Perinatal clients may receive longer lengths of stay in residential settings based on medical necessity. Following initial residential preauthorization, perinatal clients may be authorized for extensions of residential services every thirty (30) calendar days up to the length of the pregnancy and postpartum period, which is sixty (60) calendar days after the pregnancy ends, based on medical necessity.
  - Criminal justice clients
    - Criminal justice clients may receive longer lengths of stay in residential settings based on medical necessity. Following initial residential preauthorization, criminal justice clients may be authorized for extensions of residential services every thirty (30) calendar days up to six (6) months or longer, based on medical necessity.

- Youth
  - Initial residential preauthorizations for youth will authorize no more than thirty (30) calendar days at the outset of residential services.
  - For youth, the length of residential services range from one (1) to thirty (30) calendar days with a thirty (30) calendar day maximum, unless medical necessity authorizes a one-time extension of up to thirty (30) calendar days on an annual basis.
  - For youth, one extension of residential services up to thirty (30) calendar days beyond the maximum length of stay of thirty (30) calendar days may be authorized for one continuous length of stay in a one-year period (365 calendar days).
  - Residential Grace Period – Youth
    - For youth, while DMC reimbursable residential admissions are limited to only two non-continuous thirty (30) calendar day residential admissions during a one-year period, SAPC will implement a seven (7) calendar day grace period by which the residential stay for youth patients who leave (e.g., drop out) or are administratively discharged (e.g., kicked out for reason) from residential treatment within seven (7) calendar days will be reimbursed with non-DMC funds. This will help preserve the two allowable DMC reimbursable residential admissions per year.

Residential Grace Period

While DMC reimbursable residential admissions for both adults and youth are limited to only two non-continuous residential admissions during a one-year period, SAPC will implement a seven (7) calendar day grace period by which the residential stay for patients who leave (e.g., drop out) or are administratively discharged (e.g., kicked out for reason) from residential treatment within seven (7) calendar days will be reimbursed with non-DMC funds. This will help preserve the two allowable DMC reimbursable residential admissions per year. This residential grace period applies for all residential admissions beyond the first admission, with no cap.

- The first residential admission for youth will always be paid for via DMC, even if less than seven (7) calendar days. However, the residential grace period will apply for subsequent residential admissions with no cap (e.g., the residential grace period applies for all residential admissions beyond the first admission).

- In general, youth clients typically require shorter lengths of stay than adult clients and should be stabilized and then moved down to a less intensive level of care.

- Residential patients must receive regular assessments of their progress within their sixty (60) and thirty (30) calendar day residential authorizations for adult and youth populations, respectively. Given the fluid nature of clinical progression, the expectation will be that clinical progress note assessments are performed on a regular basis during residential treatment as clinically warranted and that certain patients will not require the full period of authorized residential services. In these instances, patients must be transitioned to a lower level of care as soon as clinically indicated. Required treatment plan updates every thirty (30) calendar days in the residential setting will help to facilitate these regular case reviews to ensure that patients receive care in the least restrictive setting that is clinically appropriate. Please see the Documentation section for additional details on treatment plan requirements.
- If upon clinical review, either during a focused or random retrospective review, a residential treatment case is determined to be unnecessary based on the aforementioned considerations, UM staff will have the authority to terminate/modify the current authorization and to deny ongoing reimbursement for residential services, and require transition to an appropriate lower level of care. In these instances, reimbursement for residential services that have already been provided will be maintained, but future reimbursement for the identified episode will be denied. Providers will be responsible for ensuring successful care coordination during all level of care transitions.
- Providers will be required to notify UM staff of residential discharges and to submit a completed discharge summary within twenty-four (24) hours.

Authorized services, such as Recovery Bridge Housing for adults, or medication-assisted treatment and withdrawal management for youth under age 18, are services that require authorization from SAPC, but do not require authorization prior to the provision of services.

<u>Authorized Services</u>

Authorized services are services that require approval from SAPC, but do not require authorization prior to the provision of services. In these instances, UM staff will perform concurrent reviews of care and extensions of previous authorizations, when pertinent.

The provider will be required to notify UM staff of the recommended services within three (3) calendar days via web application or fax in order to begin the authorization review process. Any request for authorization may be denied due to untimely submission (e.g., not submitted in accordance with the timeframes specified above). Notifications from providers must, at a minimum, include a completed authorization request and initial intake documentation, including assessment information. Required documentation for requests for continuation of authorized services must, at a minimum, include a completed authorization request, current treatment plan, assessment information, progress notes, and laboratory test results (if available).

UM staff will perform clinical reviews of the case being referred for authorization, based on the case review considerations listed above. Approval for initial authorization requests is based on medical necessity and ASAM Level of Care guidelines, as well as generally accepted standards of clinical practice. Consideration for ongoing authorization is based on the same criteria, as well as documented progress

and engagement in treatment. For services that require authorization, notifications will occur within the review timeframes specified in Table 13.

Clinical scenarios that require authorization, and relevant service-specific details, include:

- **Medication-Assisted Treatment (*authorization required for youth only*):**
    - Individuals under the age of 18 who initiate medication-assisted treatment (MAT). Re-authorization required every thirty (30) calendar days, until age 18, if the clinical determination is that patients under age 18 require ongoing MAT.
    - Requests for continuation of MAT for individuals under age 18 must be submitted at least seven (7) calendar days in advance of the end date of current authorization.
- **Withdrawal Management (*authorization required for youth only*)**
    - Withdrawal management (WM) for adults in any setting does not require preauthorization or authorization.
    - For youth, WM is not an ASAM level of care and is therefore not included in the DMC-ODS youth benefit package. However, WM may be approved for youth on a case-by-case basis via an authorization process if determined to be medically necessary, and may be integrated with services in other settings.
    - The provider will submit an authorization request for youth WM to the UM unit, which will conduct a concurrent review, and then approve or deny the request within five (5) calendar days of receiving the request. Providers may admit youth prior to receiving WM authorization, with the understanding that authorization denials will result in financial loss, whereas authorization approvals will be retroactively reimbursed to the date of admission.
    - Authorization for youth WM is required in all WM levels of care, including ambulatory (outpatient), residential, and inpatient.
    - Withdrawal management for youth in residential settings is considered a separate ASAM level of care than youth residential services. As such, only authorization for the youth WM services is required and an additional residential authorization is unnecessary unless patients are transitioned to residential services following their episode of WM services.
    - Youth WM authorizations authorize this service for the full duration of the episode of WM service. As a result, reauthorizations and requests for continuation of youth WM services are not applicable.
    - There is no predetermined length of stay restrictions for youth WM services, though the typical duration of WM services ranges from several days to approximately two (2) weeks. Episodes of WM for youth will be monitored.
    - Youth receiving WM services must be observed and monitored regularly to assess their progress. The expectation is that youth receiving WM services will be transitioned to a lower level of care as soon as clinically indicated.
    - If upon clinical review, either during a focused or random retrospective review, a youth WM case is determined to be unnecessary based on the aforementioned considerations, UM staff will have the authority to deny ongoing reimbursement for youth WM services, and require transition to an appropriate lower level of care. In these instances, reimbursement for youth WM services that have already been provided will be maintained, but future reimbursement for the identified episode will be denied.
    - Treatment for SUDs should occur along a continuum of care and WM is a critical point within the ASAM continuum of care. However, in and of itself, WM does not constitute adequate treatment for addiction. As such, patients who receive WM should be connected with ongoing treatment services for their addiction. Youth WM providers will be responsible for ensuring successful care coordination during all level of care transitions.

- Providers will be required to notify UM staff of youth WM discharges and to submit a completed discharge summary within three (3) calendar days of ending the service.
- When WM for youth involves medication-assisted treatment (MAT), MAT for youth under age 18 requires authorization (see above).

- **Recovery Bridge Housing (*this benefit is only available to adults*)**
  - Recovery Bridge Housing (RBH) is defined as a type of abstinence-based, peer supported housing that combines a subsidy for recovery residences with concurrent treatment in outpatient (OP), intensive outpatient (IOP), Opioid Treatment Program (OTP), or Outpatient (aka: Ambulatory) Withdrawal Management (OP-WM) settings.
  - While RBH is not officially an ASAM LOC, it serves as a bridge between the more intensive and restrictive residential treatment setting and OP/IOP/OTP/OP-WM treatment with no housing component attached. With the enhanced utilization controls of the DMC-ODS, there will likely be a greater reliance on RBH as well as other housing options for individuals in OP/IOP/OTP/OP-WM treatment settings who require recovery-oriented housing while they receive SUD treatment.
  - RBH is available for *adults* who meet <u>all</u> of the following criteria:
    - In need of a stable, safe living environment in order to best support their recovery from a SUD.
    - Belongs to one of the prioritized RBH populations (see Table 12).
    - Concurrently enrolled in treatment in OP/IOP/OTP/OP-WM treatment settings.
  - Patients eligible for RBH may be stepping down from residential treatment, or may be entering the SUD treatment system in the OP/IOP/OP-WM settings. Youth (under age 18) who require recovery housing may be eligible for placement in a group home that provides treatment and ancillary services on sites licensed by the California Department of Social Services.
  - Individuals being considered for RBH should have an expressed desire to be placed in an abstinence-based living environment in order to facilitate their recovery, and should meet the characteristics outlined in Table 12.
  - SUD providers should discuss housing preferences with patients, and combined with their professional judgment, determine if housing in RBH – which requires abstinence from drugs/alcohol and continued SUD treatment – or placement in other housing option outside of SAPC's network is more appropriate. If non-RBH is assessed to be more appropriate, SUD providers should work with appropriate staff at CES lead agencies to match homeless individuals with available housing for which they are eligible based on their VI-SPDAT score.
  - All patients being considered for RBH should first be screened for alternative access to housing through some other mechanisms (e.g. Probation provides access to recovery residences and other housing options to AB 109 patients). Some individuals may be eligible for or receiving a subsidy to pay for recovery housing from a funding source outside SAPC, such as AB 109 funding. Since RBH cannot be paid for with DMC funds, SAPC network providers should make every effort to match patients with appropriate recovery housing subsidized by another funding source whenever possible.
  - If RBH is determined to be appropriate, SAPC providers must submit an authorization request form and supporting documentation to the QI and UM Unit in order to receive a subsidy for RBH from SAPC
  - Staff from the QI and UM Unit will review the authorization request form and supporting documentation, and render a decision on authorization of the RBH subsidy. Referring providers must document the need for RBH in the patient's treatment plan.

- If patients are self-referring for RBH, staff at the OP/IOP/OP-WM agency will contact staff at the QI and UM Unit who will assess the appropriateness of placement in the RBH setting and render a decision regarding authorization.
- SAPC may authorize and subsidize up to a maximum of ninety (90) calendar days of RBH per calendar year for patients who meet the eligibility criteria specified above. Individuals who do not utilize the entirety of the ninety (90) calendar days during the year may use the remainder of the unused days later during the calendar year, as necessary.
- Perinatal patients may be eligible for lengths of stay in RBH up to the length of the pregnancy and postpartum period – the last day of the month in which the 60th day after the end of the pregnancy based on medical necessity (California Department of Health Care Services 2016).

A summary of services that require preauthorization and authorization is included in Table 14.

Table 14. Preauthorized and Authorized Services

Service Type	Initial Service Request Timeframe	Ongoing Service Request Timeframe	Notification Timeframe	Reauthorization Timeframe
PREAUTHORIZED SERVICES				
Residential Services; *for both adults and youth*	Preauthorization must be submitted prior to service delivery, unless providers elect to provide the service prior to receiving preauthorization and accept potential financial loss if the preauthorization is ultimately denied.	Re-authorization request must be submitted at least seven (7) calendar days in advance of end date of current authorization	See Table 13	Re-authorization required after sixty (60) calendar days for adults, and thirty (30) calendar days for youth, as clinically indicated (see above for residential lengths for stay for specific populations)
AUTHORIZED SERVICES				
Recovery Bridge Housing (RBH); *for adults only*	Authorization must be submitted within three (3) calendar days of initiation of service	N/A **Note**: RBH is authorized for the entire episode of service and does not require reauthorization.	See Table 13	N/A **Note**: RBH is authorized for the entire episode of service and does not require reauthorization.
Withdrawal Management for youth under age 18	Authorization must be submitted within three (3) calendar days of initiation of service	N/A **Note**: Youth withdrawal management services are authorized for the entire episode of service and do not require reauthorization.	See Table 13	N/A **Note**: Youth withdrawal management services are authorized for the entire episode of service and do not require reauthorization.

Medication-Assisted Treatment for youth under age 18	Authorization must be submitted within three (3) calendar days of initiation of service	Re-authorization request for youth MAT must be submitted at least seven (7) calendar days in advance of end date of current authorization	See Table 13	Re-authorization for youth MAT required every thirty (30) calendar days until age 18, or as clinically indicated

If after careful consideration of all case information UM staff determine that the proposed and provided services are necessary, appropriate, and in accordance with standards of clinical practice outlined in the QI and UM programs, services and reimbursement will be authorized and the applying provider will be notified in accordance with the notification timeframes listed in Table 13. Reimbursements for services will be retroactive to the date of the referral submission, pending case review and approval.

Denials of authorization will result in denial of reimbursement for services rendered and will be reviewed by supervisorial staff within the UM program and if the decision is consistent with the original denial, the applying agency will be notified of the denial decision within the timeframes listed in Table 15. Denials of authorization will result in denial of reimbursement for services rendered. Denial notifications will include information including, but not limited to:

- The action SAPC has taken or intends to take.
- The reasons for the action.
- The patient's or the provider's right to file an appeal.
- The patient's right of a State fair hearing.
- The procedures for exercising the patient's rights.
- The circumstances under which expedited resolution is available and how to request it.
- The patient's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the patient may be required to pay the costs of the services.

Patients, or providers acting on behalf of the patient, have the opportunity to review and respond to the evidence and rationale outlined in the initial denial, and may challenge a denial of DMC benefit, coverage of services, or denial of payment for services (see Complaints/Grievances and Appeal Process).

The complaint or grievance process is a process for patients, their authorized representative, or providers ("involved parties") to express dissatisfaction with elements of care including, but not limited to, quality of care, timeliness of services, and/or treatment.

Complaints/Grievances and Appeals Process

A complaint/grievance and appeals process is available for patients, their authorized representative, or providers acting on behalf of the patient and with the patient's written consent ("involved parties"). A complaint is the same as a grievance.

An "appeal" refers to a request for review of an "action," which may include:

- Denial or limited authorization of a requested service such as the type or level of service.
- Denial, suspension, or termination of a previously authorized service.

- Denial, in whole or in part, of payment for a service.
- Denial of a request to obtain services outside of the network.

A "grievance" or complaint refers to an expression of dissatisfaction about any matter other than an "action," as defined above. Possible subjects for complaints/grievances include, but are not limited to: the quality of care of services provided; the timeliness of service provision, aspects of the interpersonal relationships such as rudeness of a provider or employee; and failure to respect the patient's rights.

Involved parties may contact QI and UM staff in these instances to discuss their concerns. In many cases, a responsible and reasonable resolution can be achieved through an informal and professional discussion. However, additional action in the form of a complaint/grievance or appeal may be required in some instances. Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution. The QI and UM programs, Finance Unit, or the Contract Unit is responsible for processing these complaints/grievances and appeals, depending on the circumstances, nature of the situation and the responsibilities of the respective unit.

SAPC will provide patients reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

At the agency level, providers must have policies and procedures in place for collecting, reviewing, and acting on complaints/grievances/appeals that are filed by their patients. This process should be clear and transparent to all patients and providers, and should be integrated into the quality improvement processes of the provider agency.

Similarly, patients, their authorized representative, or providers acting on behalf of the patient and with the patient's written consent have the opportunity to file a complaint/grievance and/or appeal. Involved parties may review and respond to the evidence and rationale provided by QI and UM staff in instances of denials of authorization, and may challenge denials of DMC eligibility verification or service authorizations for levels of care.

Complaint/Grievance Process

- Providers may initiate complaints/grievances in writing by submitting a completed Complaint/Grievance/Appeal Form to the QI and UM Unit, either via web application or fax (see below for submission information).
- Clients can file a complaint by phone or in writing via web application or mail by submitting a Client Complaint Form. If clients do not submit a written Client Complaint Form, SAPC staff will complete the Client Complaint Form based on the information provided by the client. A client may also authorize, in writing, another person to act on the client's behalf
- Upon receipt, complaints/grievances will be logged by QI and UM staff and an acknowledgement letter will be sent to the requesting party within three (3) calendar days of receipt of the complaint/grievance.
- The staff making decisions on grievances/appeals will not have been involved in any previous level of review or decision making, and if deciding on any of the following, are health care professionals with appropriate clinical expertise in treating the condition:
    - An appeal of a denial that is based on lack of medical necessity.

  - A grievance regarding denial of expedited resolution of an appeal.
  - A grievance or appeal that involves clinical issues.
- Patients and/or providers are entitled to a full and fair review conducted by QI and UM staff that possess the appropriate clinical expertise.
- All complaints/grievances will be reviewed by supervisorial staff within the QI and UM program, who will work with QI and UM staff and the involved party/parties filing the complaint/grievance to research all facts associated with these inquiries and conduct additional research, such as contacting the treating provider, if necessary. Every attempt will be made to achieve a satisfactory resolution, if applicable.
- A decision regarding the grievance will be rendered within the timeframes listed in Table 15, though many complaints/grievances will be addressed sooner. If the complaint/grievance cannot be resolved within the respective timeframe, an extension of fourteen (14) calendar days may be granted by a UM supervisor.
- Decision notifications will include, but not be limited to:
  - The date and result of the grievance.
  - Reasons and rationale for decision (if decision result in denial).
  - Contact information for the reviewer.
  - Information regarding the state fair hearing process and the patient's right to continue to receive benefits while the State Fair Hearing is pending.
- In instances in which appeals are denied and not wholly resolved in favor of the patient, patients must be notified of:
  - The right to request a State Fair Hearing and how to do so.
  - The right to request to receive benefits while the State Fair Hearing is pending, and how to make the request.
  - The possibility the patient may be held liable for the cost of those benefits if the State Fair Hearing decision upholds the original denial decision.
- Complaints/grievances will be addressed as a component of the quality improvement activities within the QI and UM programs, and depending on the nature of the complaint/grievance, may trigger more targeted follow up at the provider level.
- Concerns that arise during the complaint/grievance process will be discussed with providers and are viewed as a learning opportunity for both QI and UM staff and SAPC contracted providers, with the shared goal of improving our system of SUD care.
- Complaints/grievances may be presented to the Quality Improvement / Risk Management Committee during its meetings every other month in order to identify trends, areas needing process or performance improvement, and determine necessary action steps.

An appeals process is available if patients, their authorized representative, or providers disagree with the decisions rendered by UM staff. In these situations, a formal appeal can be filed in order to challenge a denial of DMC benefit, level of care decision, or payment for services. Appeals offer an opportunity for additional review and reconsideration of denial decisions.

Appeal Process[GT3]

- Utilization management decision makers are not incentivized or rewarded to issue denials. Importantly, the goal of the UM program is to ensure appropriate utilization of SUD resources and is NOT intended to screen out patients for necessary services or create unnecessary burden for providers, which is contrary to the organizational mission and goals of SAPC.
- Appeals offer an opportunity for additional review and reconsideration of denial decisions in instances in which patients, their authorized representative, or providers may disagree with the

decisions rendered by UM staff. In these circumstances, parties may file a formal appeal to challenge denials of DMC benefit verification, level of care decisions, or payment for services.

- Patients and/or providers are entitled to a full and fair review. Appeals reviewers will consist of supervisorial and/or higher management staff.
- Appeals can be submitted in writing by forwarding a completed Complaint/Grievance/Appeal Form to the QI and UM Unit, either via web application or fax within 30 (thirty) calendar days from the date of the written decision notification for the authorization request. See below for contact information.
- Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the patient or the provider requests expedited resolution.
- The patient or provider may file an appeal either orally or in writing, and unless he or she request expedited resolution, must follow an oral filing with a written, signed, appeal.
- Upon receipt, appeals will be logged by QI and UM staff and an acknowledgement letter will be sent to the requesting party within the timeframes outlined in Table 15.
- Staff reviewing the appeal request will research the facts associated with the initial denial and conduct additional research, such as contacting the treating provider, if necessary. Reviewers will also consult the ASAM criteria and/or other appropriate clinical resources.
- The patient is provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. SAPC will inform the patient of the limited time available for this in the case of expedited resolution.
- After careful consideration of all case information, a decision will be rendered and the rationale and outcome will be conveyed to the appealing patient and/or provider, in accordance with the timeframes outlined in Table 15. If the appeal cannot be resolved within the respective timeframe, an extension of fourteen (14) calendar days may be granted by a UM supervisor.
    - Decision notifications include, but are not limited to:
        - The date and result of the appeal.
        - Reasons and rationale for decision (if decision result in denial).
        - Contact information for the reviewer.
        - Information regarding the state fair hearing process and the patient's right to continue to receive benefits while the fair hearing is pending.
    - In instances in which appeals are denied and not wholly resolved in favor of the patient, patients must be notified of:
        - The right to request a State Fair Hearing and how to do so.
        - The right to request to receive benefits while the hearing is pending, and how to make the request.
        - The possibility the patient may be held liable for the cost of those benefits if the State fair hearing decision upholds the original denial decision.
- Appeals for initial residential authorizations, and withdrawal management and MAT for youth will be expedited, according to the timeframes outlined in Table 15, whereas residential reauthorizations will follow the standard appeal timeframe.
- The expedited resolution of appeals begins when SAPC determines (in response to a request from the patient or patient representative) or the provider indicates (in making the request on the patient's behalf) that taking the time for a standard resolution could seriously jeopardize the patient's life, health, or functional status. The provider agency will be notified within the timeframe listed in Table 15.

- The patient and his or her representative should have an opportunity, before and during the appeals process, to examine the patient's case file, including medical records, and any other documents and records considered during the appeals process.
- Concerns that arise during the appeals process will be discussed with providers, may result in corrective actions, and are viewed as a learning opportunity for both QI and UM staff and SAPC contracted providers, with the shared goal of improving our system of SUD care.
- Appeals will be presented to the Quality Improvement / Risk Management Committee during its meetings every other month in order to identify trends, areas needing process or performance improvement, and determine necessary action steps.
- During the appeal process, the patient continues to receive his or her benefits if all of the following are met:
    - The patient or the provider files the appeal in a timely manner, defined as filing on or before the later of the following: within ten (10) calendar days of SAPC mailing the notice of action; or the intended effective date of SAPC's proposed action.
    - The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
    - The services were ordered by an authorized provider.
    - The patient or the patient's representative requests extension of benefits.
- If, at the patient's or patient's representative's request, SAPC continues or reinstates the patient's benefits while the appeal is pending, the benefits must be continued until one of following occurs:
    - The patient withdraws the appeal.
    - Ten (10) calendar days pass after SAPC mails the notice, providing the resolution of the appeal against the patient, unless the patient, within the ten (10) calendar day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
    - A State fair hearing office issues a hearing decision adverse to the patient (e.g., denial).
    - The time period or service limits of a previously authorized service has been met.
- Patient responsibility for services furnished while the appeal is pending.
    - If the final resolution of the appeal is adverse to the patient (e.g., denial) and upholds SAPC's action, SAPC may recover the cost of the services furnished to the patient while the appeal is pending, to the extent they were furnished solely because of the appeal.
    - If SAPC or the State fair hearing reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, SAPC must authorize and provide the disputed services promptly.
    - If SAPC or the State fair hearing office reverses a decision to deny authorization of services, and the patient received the disputed services while the appeal was pending, SAPC must pay for those services.

Contact Information:

County of Los Angeles, Department of Public Health
Substance Abuse Prevention and Control
Office of the Medical Director and Science Officer
1000 South Fremont Avenue; Building A-9 East, 3rd Floor
Alhambra, California 91803
XXX-XXX-XXXX

In all cases, patients who have exhausted the Complaint/Grievance and/or Appeals process may request a State Fair Hearing process with the California Department of Health Care Services.

Table 15. Complaint, Grievance, and Appeal Notification Timeframes

Description	Receipt Notification	Decision Notification (via email)	Written Decision Notification (via mail)
Complaint/Grievance A process of expressing dissatisfaction with elements of care including, but not limited to, quality of care, services, and/or treatment. *Must be filed within one hundred and eighty (180) calendar days of the reason for filing the complaint/grievance.	Within three (3) business days of receipt of complaint / grievance	As expeditiously as the client's health condition requires or within sixty (60) calendar days of receipt of complaint / grievance	Within sixty (60) calendar days of receipt of complaint/grievance
Standard Appeal for Residential Reauthorizations, Grievance Decisions, etc. Appeals are a formal process of challenging denial decisions involving, but not limited to, DMC eligibility, services, or level of care decisions. *Must be filed within ninety (90) calendar days from the date on the written decision notification.	Within three (3) business days of appeal	As expeditiously as the client's health condition requires or within forty-five (45) calendar days of receipt of appeal	Within forty-five (45) calendar days of receipt of appeal request
Expedited Appeal for Initial Residential Authorizations, and Withdrawal Management and Medication-Assisted Treatment for Youth under age 18. The expedited resolution of appeals begins when SAPC determines (in response to a request from the patient or patient representative), or the provider indicates (in making the request on the patient's behalf), that taking the time for a standard resolution could seriously jeopardize the patient's life, health, or functional status. Appeals for initial residential authorizations and medication-assisted will be routinely expedited. *If request for expedited resolution of an appeal is denied, it will be transferred to the timeframe for standard resolution.	Within two (2) business days of appeal	Verbal notification as soon as possible but no later than within three (3) business days of receipt of appeal	Within three (3) business days of receipt of appeal request

Description	Receipt Notification	Decision Notification (via email)	Written Decision Notification (via mail)
Written notification of this change to a standard appeal process will be provided within two (2) business days.			

Note: These timeframes may be extended by up to an additional fourteen (14) calendar days if:

- The patient or the provider, requests extension;
- SAPC justifies (to the State agency upon request) a need for additional information and how the extension is in the patient's interest.
    - SAPC will provide the patient or provider written notice of the reason for the delay and inform the involved parties of the right to file a grievance if he/she disagrees with that decision. SAPC will issue and carry out its determination as expeditiously as the patient's health condition requires and no later than the date the extension expires.

APPENDIX

Provider Staff Roles and Responsibilities

Responsibilities	Provider's Medical Director	Licensed Physician	LPHA	Registered / Certified SUD Counselors	Trained Support Staff
Initial DMC Benefit Verification	✓	✓	✓	✓	✓
Clinical Assessments	✓	✓	✓	✓	
Medical Necessity	✓	✓	✓		
Reauthorization	✓	✓	✓		
Filing Appeals	✓	✓	✓	✓	
Case Management	✓	✓	✓	✓	

Licensed Practitioner of the Health Arts (LPHA): Licensed Practitioner of the Health Arts (LPHA), which includes the following:

- Physician
- Registered Nurse
- Nurse Practitioner
- Physician Assistant
- Psychologist (Licensed/Waivered)
- Social Worker (Licensed/Waivered/Registered)
- Marriage And Family Therapist (Licensed/Waivered/Registered)
- Licensed Professional Clinical Counselor (Licensed/Waivered/Registered)
- Registered Pharmacist

These LPHAs must provide services within their individual scope of practice and receive supervision required under their respective scope of practice laws.

GLOSSARY

American Society of Addiction Medicine - **(ASAM)** - The ASAM is a professional society representing physicians and associated professionals dedicated to increasing access and improving the quality of addiction treatment. The ASAM criteria is a set of guidelines for assessing and making placement decisions for patients with addiction and co-occurring conditions.

Beneficiary Access Line (BAL) - Centralized screening and referral service that is available 24 hours a day, seven days a week. Patients can call the BAL to initiate a self-referral for treatment or can also be referred by an organization or others, including but not limited to, physical health providers, law enforcement, family members, mental health care providers, schools, and County departments.

Care Coordination - The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.

Commission on Accreditation of Rehabilitation Facilities (CARF) - An independent, nonprofit accreditor of health and human services whose mission it is to "*promote the quality, value, and optimal outcomes of services through a consultative accreditation process and continuous improvement services that center on enhancing the lives of persons served*."

Case Management - A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

Chronic Care Model (CCM) - A well-established organizational framework for chronic care management and practice improvement that identifies the six essential elements of a health care system that encourage high-quality chronic disease care: organizational support, clinical information systems, delivery system design, decision support, self-management support, and community resources.

Cognitive Behavioral Therapy (CBT) - A type of psychotherapy that is evidence-based and uses strategies based on the theory that learning processes play a critical role in the development of maladaptive behavioral patterns. Cognitive behavioral therapy focuses on examining the relationships between thoughts, feelings and behaviors.

Clinical Practice Guidelines - Recommendations for counselors/clinicians about the care of patients with specific conditions, which should be based on the best available research evidence and practice experience.

Co-occurring Disorders (COD) - Describes the presence of two or more health conditions at the same time. For example, a person may have a substance use disorder as well as a mental health condition, or a substance use disorder as well as a physical health condition.

Continuum of Care - A concept involving an integrated system of care that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensities of care.

Continuous Quality Improvement (CQI) - An approach to quality management that is based on concepts of quality improvement and performance measurement, and encourages health care team members to continuously identify opportunities for improvement. It employs a patient-centered philosophy and long-term approach to provide tools to help quantify and inform program planning.

Diagnostic and Statistical Manual of Mental Disorders (DSM) - The standard classification of mental disorders used by a wide range of health and mental health professionals.

Evidence-Based Practice (EBP) - A clinical approach that applies the best available research results to inform health care decisions. Health care professionals who perform evidence-based practice use research evidence along with clinical expertise and patient preferences.

Licensed Clinical Social Worker (LCSW) - Professionals that have either a masters or doctoral level degree in social work, and licensure or professional supervision that allows them to provide counseling and psychotherapy from a social work orientation. They are qualified to assess, diagnose and treat mental and emotional conditions and addictions.

Licensed Mental Health Counselor (LMHC) - Professionals that hold a master's degree in counseling or another closely related field in behavioral health care. Although their scope of practice varies, LMHCs are generally qualified to assess, diagnose and treat mental and emotional conditions and addictions.

Licensed Marriage and Family Therapists (LMFT) - Master's level professionals trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems.

Licensed Practitioners of the Healing Arts (LPHA) - Term that includes physicians, nurse practitioners, physician assistants, registered nurses, registered pharmacists, licensed clinical psychologists, licensed clinical social workers, licensed clinical professional counselors, and licensed marriage and family therapists.

Medication-Assisted Treatments (MAT) - The use of medications, in combination with counseling and behavioral therapies, to comprehensively treat substance use disorders and provide a whole-patient approach to treatment that includes addressing the biomedical aspects of addiction.

Medical Necessity Criteria - A definition of accepted health care services that involves diagnosis, impairment, and intervention. Medical necessity in Los Angeles County requires that individuals have at least one diagnosis from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders. The service must also meet a recommended level of intervention consistent with the current edition of the American Society of Addiction Medicine (ASAM) placement guidelines, which include a consideration of biopsychosocial severity.

Motivational Interviewing (MI) - A type of evidence based practice and clinical interviewing approach that is a directive, patient-centered couseling style designed to elicit behavior change by helping

patients to explore and resolve ambivalence towards change.

Opioid Treatment Programs (OTP) - Treatment programs that provide opioid treatment, including the use of medication-assisted treatments such as methadone and buprenorphine, and comprehensive medical, psychosocial, and addiction treatment for opioid-dependent individuals in a therapeutic environment.

Progress note formats: SOAP, GIRP, SIRP, or BIRP - SOAP (Subjective, Objective, Assessment and Plan), GIRP (Goals, Intervention, Response and Plan), and SIRP (Situation, Intervention, Response and Progress), and the BIRP (Behavior, Intervention, Response and Plan) are specific methods of documentation that describe the format and content of progress notes to ensure communication and monitoring of patient interactions.

Quality Improvement (QI and UM) - The planned and systematic activities that are implemented in order to ensure that the quality requirements for a service is fulfilled, with the greater goal of measurable improvements in health care services. The QI and UM programs are responsible for ensuring that the provision of substance use disorder services aligns with SAPC's organizational mission and goals, and that services follow a standard of clinical practice consistent with medical necessity, best practice, and level of care guidelines described by the American Society of Addiction Medicine (ASAM).

Quality Improvement Project (QIP) - A provider-level project that follows the Continuous Quality Improvement model in order to identify and quantify issues or problems, and subsequent interventions, with the goal of improving care or services.

Performance Management - The strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results. Ideally, these practices should be integrated into core operations, and can occur at multiple levels, including the program, organization or system level.

Recovery Support Services (RSS) - Non-clinical services that foster health and resilience in individuals and families by helping them to navigate systems of care, and reduce barriers to employment, housing, education, and other life goals.

Risk, Need, Responsivity (RNR) - An evidence-based practice framework that emphasizes that criminal justice agencies should match offenders to services and programs based on their risk and need factors.

Screening, Brief intervention, and referral to treatment (SBIRT) - An evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence of alcohol and other drugs.

Substance Abuse Prevention and Control (SAPC) - The Los Angeles County agency responsible for leading and administering a full spectrum of prevention, treatment, and recovery support services for County residents.

Standardized Documentation - A structured method of clinical documentation that ensures an efficient way to organize and communicate with other providers. Examples include the SOAP, GIRP, SIRP, and BIRP progress note formats mentioned in this document.

Treatment Improvement Protocol (TIP) - A series of best-practice manuals for the treatment of substance use and other related disorders. The TIP series is published by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services.

Young Adults - Defined as young individuals between the ages of 16 and 25 who have unique service challenges due to their developmental stage and transition from adolescence to adulthood, some of whom may have received services from the adolescent service system and may need continued services and supports from the adult system

Utilization Management (UM) - The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control